The Manitoba Medical Review

Vol. 28 SEPTEMBER, 1948 No. 9

UROLOGY

The Use of Streptomycin In Urinary Infections

David Swartz, M.D. (Man.), F.R.C.S. (Edin. and Canada)

The following is a resume of data concerning the treatment of 16 cases of urinary infection with streptomycin. The majority of these cases are world war veterans treated at the Deer Lodge Hospital.

Table No. 1

	Diagnosis	Penicillin and Sulfa	Culture (Pre.)	Streptomycin Sensitivity	Streptomycin	Culture (Post)	Streptomycin Sensitivity	Clinical Results
Case 1 Male Age 19	Infection following plastic procedure for hydronephrosis	Pen. 5,000,000 units Sulfa-40gms. 10 days	Proteus Vulgaris Proteus Morgagni Strep. Fecalis	2 Mic. per cc. 5 Mic. per cc. 70 Mic. per cc.	18 gms. in 9 days	Proteus Morgagni Strep. Fecalis Aerob Aerogenes Pseud. Aerug.	100 Mic. per cc. 100 Mic. per cc. 100 Mic. per cc. 100 Mic. per c.c	Improved
Case 2, Male Age 57	Infection following operative removal renal calculi	Pen. 5,000,000 units in 10 days Sulfa—80 gms. 2 courses.	Pseud. Aerug. Aer. Aerog. Staph. Alb. Coag.	100 Mic. per cc. 10 Mic. per cc. 10 Mic. per cc.	22 gms. 11 days	Pseud Aerug. Aer. Aerog. Strep. Fecalis	100 Mic. per cc. 100 Mic. per cc. 100 Mic. per cc.	Cured
Case 3, Male Age 35	Chronic pyelonephritis and prostatitis avitaminosis (Hong Kong Veteran)	Pen. 15,000,000 units, 6 courses Sulfa—240 gms. 6 courses	Aer. Aerog. Atypical B. Co..	8 Mic. per cc. 100 Mic. per cc	6 grams 5 days	Aer. Aerog. Atypical B. Coli	100 Mic. per cc. 100 Mic. per cc.	No change
Case 4, Male Age 29	Diabetes Pyelonephritis Prostatic Abscess	Pen. 5,000,000 units, 3 courses Sulfa—100 gms. 3 courses	Aer. Aerog. B. Coli. Strep. Viridans Staph. Albus	10 Mic. per cc. 15 Mic. per cc. 20 Mic. per cc. 20 Mic. per cc.	10 gms. 8 days	Aer. Aerog. Staph. Albus.	100 Mic. per c.c. 100 Mic. per cc.	Died
Case 5, Male Age 20	Neurogenic Bladder with urinary infection	Pen. 4,500,000 units, several courses. Sulfa Mand. Acid	Esch. Coli.. B. Proteus	30 Mic. per cc. 20 Mic. per cc.	12 gms. in 6 days	Esch. Coli.		Improved
Case 6 Male Age 52	Pyelonephritis Due to Calculus	Pen. 4,350,000 units Sulfa—8 Gms.	Esch. Coli. B. Proteus Strep. Fecalis		15 gms. in 7 days, still under treatment	B. Aerogenes		Dramatic, immediate effect
Case 7 Male Age 21	Congen. Bilat. Hydroneph. and Hydro-ureter with infection	Pen. 6,500,000 units Sulfa—11 gms.	Friendander's Bac. B. Aerogenes	50 Mic. per cc.	10 gms. in 5 days	Strep. Fecalis Esch. Coli. B. Aerogenes		Only Temporary effect
Case 8 Male Age 50	Pyelonephritis following Prostatectomy	Pen. 1,120,000 units Sulfa—16 gms.	B. Proteus Vulgaris B. Aerogenes	10 Mic. per cc. 10 Mic. per cc.	20 gms. in 10 days	Esch. Coli. B. Aerogenes		Clinical improvement persisted to recovery
Case 9 Male Age 23	Acute N.S.U.	None	Esch. Coli. Aer. Aerog.	5 Mic. per cc. 3 Mic. per cc.	4 gms. in 2 days	Sterile		Cured
Case 10 Male Age 36	N.S.U. and Chr. Prost.	Pen. 10,000,000 units, 3 courses Sulfa—200 gms. 5 courses	Strep. Fecalis Mixed Strep.	50 Mic. per cc. 10 Mic. per cc.	30 gms in 12 days	S. Fecalis	100 Mic. per cc.	Remission
Case 11 Male Age 22	V.D.G. then N.S.U. and Prostatitis	Pen. 2,000,000 units Sulfa—40 gms.	Strep. Viridans	15 Mic. per cc.	6 gms. in 3 days	Pus, but no growth		Clinical improvement
Case 12 Male	N.S.U. and Cystitis	Pen. 2,500,000 units Sulfa—40 gms.	Staph. Aureus. Diphtheroids	15 Mic. per cc. 30 Mic. per cc.	36 gms. in 18 days	Sterile		Cured
Case 13 Male Age 30	N.S.U. Prostatitis	Pen. 10,000,000 units, 5 courses Sulfa—80 gms. 3 courses	Staph. Albus Hem. Staph. Aureus Diphtheroids	15 Mic. per cc. 15 Mic. per cc. 25 Mic. per cc.	25 gms. in 10 days	Staph. Albus Hem. Diphtheroids	50 units per cc. 100 units per cc.	No effect
Case 14 Male Age 31	Prostatitis	Pen. 3,700,000 units Sulfa—5 gms.	Aer. Aerog.	10 Mic. per cc.	8 gms. in 4 days	Diphtheroids		Prostatic smear free of pus
Case 15 Female Age 26	Uretero-Sigmoid Transplant	Pen. 1,000,000 units Sulfa—40 gms.			20 gms. in 10 days			Clinical improvement
Case 16 Male Age 30	Uretero-Sigmoid Transplant	Pen. 4,000,000 in 14 days Sulfa—40 gms.			15 gms in 10 days			Clinical improvement

In practically all cases other methods of treatment were tried and failed prior to the administration of streptomycin. The organisms were both penicillin and sulfa resistant.

Eight cases of upper urinary tract infection were given a course of streptomycin following intensive therapy with penicillin and sulfathiazole. The most favorable and dramatic results were obtained in those cases that were not complicated by other factors such as obstruction, calculi, avitaminosis, diabetes and paraplegia.

Two cases of uretero-sigmoid transplantation showed clinical improvement during the critical post-operative phase. The organisms involved were the gram negative bacilli and streptococcus fecalis.

Two cases of non-specific urethritis were cured. In one of these there was no previous medication. Four cases of non-specific urethritis complicated by prostatitis showed variable but inconclusive response.

There were no toxic effects in this series but in no case was there prolonged administration of the drug.

The following table indicates the sensitivity of organisms to streptomycin with particular reference to urinary infections. While the gonococcus is listed amongst the more sensitive organisms, penicillin is still considered the drug of choice to combat this infection. Gram + cocci are not entirely insensitive and have shown very definite response to streptomycin in many of the mixed infections. The Proteus is probably the least resistant of all organisms to streptomycin. This sensitivity is enhanced by the splitting of urea with the production of ammonia in an alkaline medium.

Table No. 2

Sensitivity of Organisms to Streptomycin

Ineffective

- Spores
- Fungi
- Viruses
- Protozoa

Most Effective

- Esch Coli
- Proteus Vulgaris
- Proteus Ammoniac
- Proteus Morgagni
- Aerobacter Aerogenes
- Klebsiella Pneumoniae (Friedlander)
- Gonococcus

Less Effective

- Pseudomonas Aeruginosa
- Salmonelleae
- Strep. Fecalis
- Other Entero Cocci
- Diphtheroids
- Hemophilus Influenzae

Variable Effects

- Gram + Cocci

Evidence of Some Effect

- Myco Bacterium Tuberculosis

It is interesting to note that up to 68% of streptomycin is excreted in the urine within 12 hours. In patients with renal damage, there is diminished excretion and greater blood concentration.

Dosage

Because of high urinary excretion of streptomycin, the dosage may be smaller than in the case of non-urinary infections.

If the organism is sensitive to 10 units or less per cc, the dose should be 1 gram daily. If resistant to 10 and sensitive to 30 units or less per cc, the minimum dose should be 2 grams daily. If resistant to 30 and sensitive to 50 units or less per cc the minimum dose should be 3 grams daily. If organisms are resistant up to 100 units per cc dosage should be 3 to 6 grams daily. In mixed infections where there are organisms sensitive to penicillin and the sulfas, it is desirable to eradicate those organisms before administration of streptomycin. However, streptomycin therapy may be commenced without stopping penicillin and sulfa.

Some Observations Regarding the Treatment of Urinary Infections With Streptomycin

1. The anti biotic effect of streptomycin is greater in an alkaline than in an acid medium. Alkalies should therefore be given during the administration of this drug.

2. Wide variation exists in susceptibility to streptomycin among different species of bacteria and among different strains of the same species. It is therefore important that streptomycin sensitivity of the specific organism causing infection be determined before treatment is begun.

3. Practically all organisms, common to urinary infection, are capable of developing resistance to streptomycin. This is produced by the administration of sub-lethal doses. The initial dosage should therefore be high enough to immediately control infection.

4. Single organism infections respond better than mixed infections.

5. To obtain the best results, the underlying anatomic abnormality must first be corrected. Ex. The presence of a calculus or obstruction from any cause will conspire to maintain infection.

In the neurogenic bladder, the factors initially

sponsible for infection are difficult to eliminate. has been noted that sterilization of urine is tained but within a week after cessation of treatent, reinfection has occurred.

Its use in uretero-sigmoid anastamosis is palative rather than curative because of persistent infection.

6. Many cases show clinical improvement ithout bacterial remission. This may be to some tent eliminated by increased initial dosage to event development of resistance during treatent.

7. It is essential to treat an infection for a longer eriod than appears necessary and to follow for a eek or more after cessation of the drug before nsidering a case cured.

8. Streptomycin is an effective agent in many ses of anterior urethritis whether due to G.C. or n specific organisms. Prostatitis and epididyitis do not respond. Studies of prostatic secretion nd assays of prostate glands removed at autopsies patients who had received streptomycin, failed reveal assayable amounts of streptomycin Palaski). This also applies to the epididymis. his would indicate that streptomycin does not find its way into the prostate or epididymis in sufficient amount to kill organisms.

"The Journal of Venereal disease information." Vol. 28. No. 1. January, 1947. P 1-6. E. J. Palaski, Capt. M.C., U.S.A.

Conclusions

1. The value of streptomycin as a urinary antiseptic is limited by the tendency on the part of organisms to develop resistance to the drug.

2. Surgical procedures necessary to maintain normal urinary function should precede or accompany streptomycin therapy.

3. Streptomycin is useful as a pre and post-operative measure to reduce operative risk.

4. Streptomycin may be a life-saving measure in controlling an acute urinary infection and associated septicaemia.

5. Streptomycin is by no means the complete answer to the gap that still exists, nevertheless, it plays a very important role in the treatment of urinary infections.

Assistance by Dr. Jack O'Keefe, Deer Lodge Hospital, in reviewing the above cases is gratefully acknowledged.

SURGERY

Treatment of Esophageal Achalasia or Cardiospasm: Report of a Case Treated Surgically After Bougienage Failed

J. E. Isaac, M.D.*

Inability to swallow solid foods or cold water, and/or pain on attempting to swallow with resulting regurgitation, development of gradually increasing weakness, loss of weight, secondary anaemia, together with many other dietary deficiencies over a period of years, are indeed most distressing to an individual with a healthy appetite.

Achalasia was recognized as early as 1679 when Thomas Willis, in his Volume on Pharmaceutica Rationalis, recorded a case with symptoms of lower esophageal obstruction and devised an instrument like a rod, made of whale bone with a little round button of sponge fixed to the tip of it, to be used when all medicine had failed. This was used by the sick man to push food down past the obstruction into the stomach. This method of treatment by bougienage, except for modification of the instrument used, is still in use and only in certain cases is surgery necessary.

Again in 1889 in the Boston Medical and Surgical Journal Osgood[1] described six cases of cardiospasm.

*Department of Surgery, Winnipeg Clinic, Winnipeg, Man.

Incidence

Achalasia is second only to carcinoma as a cause of difficulty in swallowing. Guisiz, quoted by Schiebel[2] and Durham, found that 17.4 per cent of 946 patients requiring esophagoscopic examination for esophageal pain had achalasia. In Walton's[3] series of oesophageal lesions, 17.8 per cent were due to achalasia.

Symptoms

The symptoms consist primarily of pain, dysphagia, and regurgitation of food. Pain on swallowing is present in 60-70 per cent of cases, which is in sharp contrast to the absence of pain in carcinoma (Schiebel). Cold drinks are often more poorly tolerated than semi-solid foods.

In the case history following, the patient had been unable to drink cold water for eight years. The pain is usually felt behind the lower sternum but may radiate upwards into the cervical region, the angle of the jaw, and the mastoid region (Alvarez[4]). In some instances it is felt in the back at the level of the 10th to 12th thoracic vertebrae. Weight loss is common, varying with degree of dysphagia and obstruction. Vomiting may occur shortly after meals or not until evening, or only after several days—depending on the degree and capacity of the mega-esophagus. In milder cases, the patient may get along without vomiting, but

may have to stand to swallow or require great quantities of warm water to effect the descent of the bolus of food. There may be periods of remission and exacerbation. The latter may correspond to periods of emotional conflict, (Jacobson[5], Bruhl[6], Sudhues[7], and Weiss[8]), but in some instances no psychosomatic relationship can be discovered. Achalasia may be accentuated by fear —thus, fear of regurgitation produces inability to swallow in public places whereas at home there may be little difficulty. In other cases it may be secondary to gall bladder disease, esophagitis, foreign body in the esophagus, peptic ulcer, or diaphragmatic hernia; all these, as well as carcinoma, must be ruled out as primary or associated conditions.

Diagnosis

The foregoing symptoms suggest an esophageal lesion and Roentgenographic studies will as a rule be diagnostic. In achalasia, the x-ray shows a smooth olive-tip type or cigar type of obstruction at the cardia with or without dilatation of the esophagus above. The outline may at first be ill defined because of accumulated food and this may require esophageal lavage. Endoscopic examinations are important in diagnosis and may reveal considerable esophagitis secondary to retention of food.

Etiology

As the theories regarding the cause of the obstruction at the esophago-gastric junction changed, the diagnostic names changed. Examples of some are: cardiospasm, congenital dilatation of esophagus, phrenospasm, achalasia of the cardia, atony of esophagus and mega-esophagus, kinking of esophagus, pressure from left lobe of liver, fibrosis of peri-esophageal connective tissue, esophagectasia and the ever present idiophathic dilatation of esophagus; "cardiospasm: a psychosomatic disorder" is the most recent addition.

The long list of diagnostic names is an indication that the exact nature of the disturbed mechanism is unknown and probably varies. Ochsner and Debakey[9], Schmidt[10], Heyrovsky[11], Vinson[12], and others have discussed rather fully the causative agents in their respective articles. The following is a brief discussion to indicate the theoretical background and the resultant trends in therapy.

The congenital theory naturally had two groups of followers: viz. those concerned with the main body of the esophagus and those thinking in terms of the cardia. As a result, plications of the esophagus as well as excision of longitudinal strips were attempted but without success and were therefore discontinued. Freeman[13], thinking in terms of congenital elongation rather than the dilatation, advocated an artificial intussuscep[tion] of cervical portion into mid-thoracic por[tion] through a cervical incision.

Procedures based on the theory of congen[ital] spasm or stricture of the cardia have been [the] more successful and more rational. In 1[913] Mikulicz dilated the cardia by opening the stom[ach] and using his finger as a bougie. Later he devi[sed] an instrument for performing the dilatat[ion] through the invaginated stomach wall, there[by] avoiding contamination of the peritoneal cav[ity]. The relief, however, was by no means permane[nt] as several cases later required surgery. In 1[914] Heller first performed an operation similar to [the] Fredet-Rammstedt procedure; and repeated [the] operation 21 times with improvement in 80% a[nd] no mortality.

In 1910 Heyrovsky first performed an esophag[o]-gastrostomy, leaving the actual cardio-esophag[eal] junction intact. This acted much as a spur a[nd] results were greatly improved when Womack modified this in a fashion not unlike the Finn[ey] pyloroplasty. Since then, numerous surgeons, in[-] cluding Ochsner and Debakey[9], Kredel[15], etc., ha[ve] carried out this procedure in many cases wi[th] excellent results and low mortality. The occasion[al] case even after this cardio-esophagoplasty has re[-] quired bougienage.

Procedures based on the neurogenic theori[es] will just be mentioned. Anatomically, sympathe[tic] fibres proceed from the inferior cervical ganglio[n] and the coeliac ganglion to the esophagus. Para[-] sympathetic fibres from both vagi pass to the esophagus and it is these fibres that initiate peristaltic passage of a bolus of food (Schiebel[er]). Section of these fibres alone as high as 6-8 cm. above the diaphragm, as done in supradiaphragmatic vagotomy, will not result in cardiospasm or achalasia although invariably gastric atony results—often to an alarming degree. In dogs Grondahl and Haney[16] produced achalasia by dividing esophageal musculature to the mucosa plus sectioning both vagi, whereas either one procedure alone would not produce the same effect. Knight[17] working with cats, believed that they could not only reproduce achalasia by sectioning both vagi but could relieve it by sympathectomy (the musculature of the esophagus in cats, apes, and man is composed of similar fibres). This, however, could not be borne out by subsequent experiments.

Medical therapy based upon the principle of stimulation or inhibition of the activity of the sympathetic and parasympathetic systems has proved ineffective or transient. Some of the drugs tried were morphine sulphate, amyl nitrate, insulin, atropine sulphate, etc.

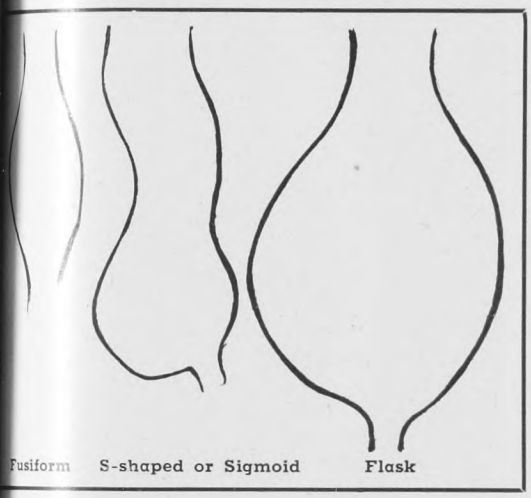
Mechanical dilatation has proven effective in the vast majority of cases. We have seen how it was carried out by Mikulicz. The simpler method

troducing a sound through the mouth has been d in more than 1,200 cases as reported from the yo Clinic. In an analysis of 805 cases, 620 ients, or 71% were found as well with one or e dilatations; in 32 there was no improvement. e died in hospital from esophageal rupture and died of starvation.

Plummer advocated the Russell hydrostatic tor as a relatively safe procedure because pain roduced in most instances by dilatation of the dia. This enables the operator to judge the unt of pressure he can use.

Pathology

Lambert[18] stressed the gross pathology more n the microscopic and classifies the cases into ee types:



These forms probably represent variations in gree of dilatation and lengthening of the eso- agus subsequent to obstruction. The esophageal all may become thicker or appear normal and the ucosa may be hypertrophied and ulceration of ucus membrane may be present. Schiebel and urham claim the major complication without erapy has been pulmonary infection due to gurgitation of food which often occurs as over- ow at night. Others are aggravations of an already isting emotional instability, bleeding and cough. eath, due to starvation, has occurred. Complica- ons following or during treatment by dilatation e the same as the aforementioned with the dition of rupture of the esophagus.

Therapy

Many degrees of achalasia are seen in actual ily practice. In fact, frequently one can produce mptoms of cardiospasm in normal individuals ho are greatly overheated and physically ex- austed by administering cold water. Some have mptoms only when emotionally disturbed. Against these mild cases, Schiebel[2] classifies the more serious ones into: 1. Those losing or having lost weight and remaining in a constantly undernourished state; 2. Those who have marked dysphagia associated with substernal pain and sense of suffocation; 3. Those with actual vomiting. These latter categories require more than advice and antispasmodics. In many of these cases bougienage is effective. When, then, is a surgical procedure such as cardio-esophagoplasty indicated or what are the criteria for surgical intervention. Schiebel quotes the following factors as an indication for interference:

1. When roentgenographic examination discloses increased length of esophagus with sigmoid or flask shapes. He claims in those cases bougienage is difficult and must be kept up constantly.

2. When the patient does not tolerate bougienage well because of fear and severe pain.

3. When a patient under proper rest and with the right type of food and being reasonably free of emotional instability requires frequent dilatation, esophagogastrostomy may be recommended as a procedure with high percentage of cure.

4. Finally, when geographically or financially the patient is unable to obtain frequent dilatation.

When such factors exist or co-exist, operation is indicated and desirable and the technique described by Alton, Ochsner and others and as carried out in the case below has been credited with a high percentage of success. Schiebel and Durham report four cases followed from 6 to 35 months and the patients were clinically and roentgenographically cured. Here, as in vagotomy, the transabdominal approach has largely replaced the transthoracic route.

Patient, a female, age 48, reported Feb. 2, 1948, complaining of:

1. Dysphagia and pain on swallowing since 1940.
2. Loss of 30 pounds of weight during first year of symptoms.
3. Occasional vomiting five to ten minutes p.c. with relief of distress.

Examination:

Patient was an aesthenic individual with deep epigastric tenderness.

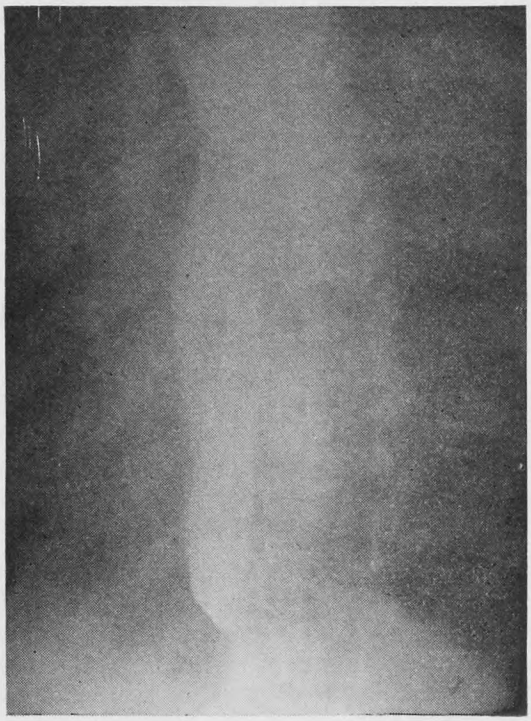
Visualization of oesophagus showed marked dilatation and a smooth funnel-shaped cardiac end, and barium did not pass into the stomach for 20 minutes—(figure 2). At five hours there was still barium in oesophagus as compared to a mild degree of cardiospasm in 1943 (figure 1).

Visualization of gall bladder showed a non functioning gall bladder with two indefinite shadows. She had a secondary anaemia of 69%. Hypoproteineuria of 5.7%.

Patient had several attempts at bougienage in 1943 with very temporary relief and refused repe-

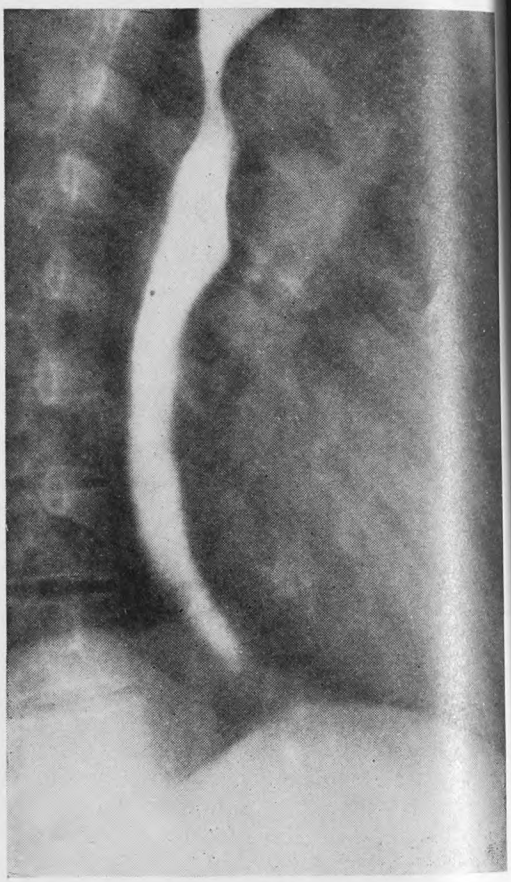
tition of this form of treatment because of fear and pain. On February 20, 1948, the author performed an oesophago-gastrostomy and cholecystectomy. Patient had an uneventful post-operative course. She painlessly swallowed cold water the second day for the first time since 19 On the fourth day a high protein liquid diet w commenced which was rapidly increased to sem solid and solid food. She left the hospital on t twelfth post-operative day and has experience no dysphagia since. In a recheck of the oesophag on April 23, 1948, approximately two months sub sequent to surgery the size of the oesophagus wa demonstrated to be within normal limits.

Figure 2



X-ray of oesophagus 1948, showing cardiospasm with retention of barium and dilated (almost sigmoid) oesophagus. Barium delayed 20 minutes before entering stomach.

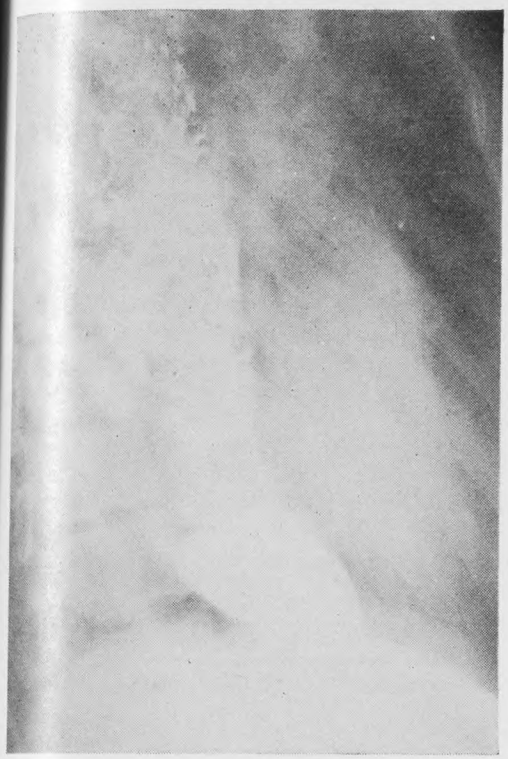
Figure 1



X-ray of oesophagus 1943, showing cardiospasm without dilatation of oesophagus.

Guenther W. Nagel[19], writing in The Medical Clinics of North America, prefers to believe that cardiospasm and mega-esophagus are two different lesions rather than that mega-esophagus is an advanced state of cardiospasm. The case just presented is proof that mega-esophagus may be secondary to cardiospasm and the two may be different phases of the same condition.

Another similar case of a male, age 64, has since been done with complete clinical cure.



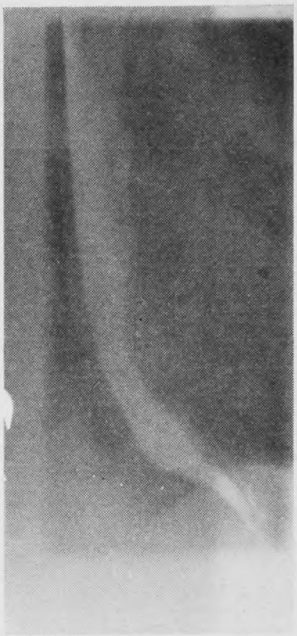


Figure 3

X-ray of oesophagus six weeks post - operatively showing oesophagus normal in size and no delay in passage of barium.

References

1. Osgood, Hamilton; A Peculiar Form of Oesophagismus, Boston M. & S.J. 120; 401-5, 1889.
2. Schiebel, H. M.; Treatment of Esophageal Achalasia or Cardiospasm, Surgery 20; 558-70, Oct., 1946.
3. Walton, A. J.; The Surgical Treatment of Cardiospasm, Brit. J. Surg. 12; 701-737, 1925.
4. Alvarez, W. C.; The Mechanics of the Digestive Tract, Ed. 2, New York, 1928, Paul B. Hoeber, Inc., pp. 82-93.
5. Jacobson, Edmund; Spastic Esophagus and Mucous Colitis; Etiology and Treatment by Progressive Relaxation, Arch. Int. Med. 39; 433-445, 1927.
6. Bruhl, H.; Der kindliche Oesophagospasmus, Ztscher. f Laryng., Rhin., Otol. 21; 1, 1931.
7. Sudhues, Maria; Uber den Speiseronrenkrampf beim Kinde, Arch. f. Kinderh. 96; 65-88, 1932.
8. Weiss, Edward; Cardiospasm; A Psychosomatic Disorder, Phychosom. Med. 6; 58-70, 1944.
9. Ochsner, Alton, and DeBakey, Michael; The Surgical Treatment of Achalasia of the Oesophagus, Surg., Gynec. & Obst. 72; 290-295, 1941.
10. Schmidt, Herbert W.; Diffuse Spasm of the Lower Half of the Oesophagus, Am. J. Digest. Dis. 6; 693-700, 1939.
11. Heyrovsky, H.; Casuistik und Therapie der idiopathischen Dilation der Seiseroehre, Oesophago-Gastroanastomose, Arch. f. klin. Chir. 100; 703, 1913.
12. Vinson, Porter C.; Cardiospasm, Am. J. Surg. 56; 79-85, 1942.
13. Freeman, L.; An Operation for Relief of Cardiospasm Associated with Dilatation and Tortuosity of the Esophagus, Ann. Surg. 78; 173-5, 1923.
14. Womack, N. A.; Esophagoplasty for Esophageal Achalasia, S. Clin. North America 18; 1241-1254, 1938.
15. Kredel, Frederick E.; Surgical Treatment of Cardiospasm, South. Med. & Surg. 104; 258-259, 1942.
16. Grondahl, J. W., and Haney, H. F.; An Attempt to Produce Experimental Cardiospasm in Dogs, Proc. Soc. Exper. Biol. & Med. 44; 126-129, 1940.
17. Knight, G. C.; The Relation of the Extrinsic Nerves to the Functional Activity of the Esophagus, Brit. J. Surg. 22; 155-168, 1934.
    Knight, G. C., and Adamson, W. A. D.; Achalasia of Cardia, Proc. Roy. Soc. Med. 28; 891-897, 1935.
    Knight, G. C.; Sympathectomy in the Treatment of Achalasia of the Cardia, Brit. J. Surg. 22; 864-876, 1935.
18. Lambert, A. U. S.; Treatment of Difuse Dilitation of the Esophagus by Operation, Surg., Gynec. & Obst. 18; 1, 1914.
19. Nagel, Gunther W.; Lesions of the Esophagus, M. Clin. North America, Mar., 363-372, 1948.

Winnipeg Medical Society

A very capable programme committee of Doctors A. E. Childe (Chairman), Harry Medovy, Frank Mathewson and L. R. Coke, has been active for some time in preparation for the meetings this coming year. The first meeting, planned for October 1st, will include Dr. Irvine McQuarrie, Professor of Pediatrics, University of Minnesota, as the chief speaker. He has promised to address us on a subject of special interest to General Practitioners. There will not be a meeting during the regular time in October because of the Manitoba Medical Association Meeting. Plans are well under way for presentations in November and December and a symposium on streptomycin, led by Dr. J. D. Adamson, is being prepared for one of the above months. Dr. Jack McKenty will head the membership committee; other standing committees are still in the formative stages.

CANCER

Edited by D. W. Penner, M.D.

Abstract

Miller, Norman F.; Carcinoma of the Uterus, Ovary and Tube. J.A.M.A., 136: 163-169, Jan. 17, 1948.

The material on which this article is based represents 27 years experience and observation of over 3,000 patients with cancer of the female genital organs. Of these 2,500 have had a 100% follow up. The author points out that as one's experience with cancer increases he is apt to become pessimistic with his poor results since most cancers when first seen are in an advanced stage. The author deplores the attitude of sitting back and waiting for a new cancer cure and suggests instead making better use of existing procedures now available. Survival curves in cancer cases continue to show improvement, therefore there is reason to be hopeful.

Cancer of the Cervix

The uterine cervix is the commonest site for cancer of the female generative tract constituting 65% of all cancers of these organs.

This condition may exist quiescent in a highly localized form for many years. Most cancers of the cervix are advanced when first seen. The main reasons are: (a) the undeveloped program of periodic health examinations, and (b) delay on the part of the patients in seeking medical advice after the onset of symptoms. The author presents charts showing the average wasted time from onset of first symptom to treatment as varying from 6 to 12 months, and also presents figures to show that with this delay the average cure rate is rapidly decreased.

A 40% five-year absolute survival rate is possible because of the anatomic location and growth characteristics. (Earlier cases permit 75 to 100% survival rate).

Regular periodic examination of the cervix plus correction of minor lesions and biopsy for all suspicious lesions followed by prompt treatment in proved cases would reduce tremendously the mortality from this cause.

No convincing evidence has as yet been produced concerning the predisposing relationship between common benign lesions of the cervix and cancer. Correction of all common cervical lesions is indicated on the grounds that cancer does not commonly appear in a healthy organ.

Over 90% are of the epidermoid or squamous cell variety, most of the remainder being adenocarcinomas. In its earlier stages the cancer is most commonly found at the junction of the squamous epithelium of the vaginal face of the cervix and columnar epithelium of the cervical canal. Spread occurs along or just beneath the surface until the entire vaginal cervix is involved. Further spread occurs by extension into the parametrial tissues, broad and sacro-uterine ligaments, bladder and vaginal mucosa. Extension also takes place by way of the lymphatics to the regional lymph nodes, and it is the cancer cells in the parametrial tissues and involved lymph nodes that present the greatest obstacle to achieving a cure. Stenosis of lower colon or rectum may require colostomy. Pain due to osseous metastases or encroachment on spinal or sciatic nerves may require cordotomy for relief. Death may result from encroachment on and stenosis of the ureters. In rare cases death results from pulmonary pneumonia caused by pulmonary metastases and secondary infection.

Symptoms of Cancer of the Cervix

Early pre-invasive lesions are commonly asymptomatic. Symptoms are usually present when invasion gets well under way and become more pronounced with extension of the neoplasm. The principal and often only symptom is spotting or bleeding. This may be slight and is characterized by being: intermenstrual or irregular, progressive, of increasing frequency and amount, and prone to follow trauma, such as post-coital spotting. About 15% of patients with cancer of the cervix complain only of leukorrhea, a non-bloody watery, serous or purulent discharge. Some are symptom free, further emphasizing the need for periodic examination.

Diagnosis of Cancer of the Cervix

Every case should be proved by taking tissue for histologic examination. In most cases biopsy of the cervix is an office procedure and requires no anaesthesia. When facilities are available for prompt evaluation the vaginal and cervical smear technics can be useful. Patients with positive smears should return for biopsy and histologic confirmation. Taking the smear is simple enough, the interpretation, however, calls for skill in cytology.

Clinical Grouping and Histologic Grading of Cancer of Cervix

Generally the clinical extent of the disease gives a more accurate index regarding ultimate prognosis and response to treatment than does the histologic grade of the neoplasm.

Clinical group 1 includes very early proved cases confined to a small portion of the cervix. Group 2 includes more advanced cancers but still

confined to the cervix. Group 3 includes cancers with questionable extension beyond the cervix where it is difficult to decide whether or not there is parametrial extension. Group 4 includes advanced cases whether they reveal extension into vaginal vault, parametrial invasion or remote metastases.

Prognosis for Cancer of the Cervix

The prognosis depends upon the clinical stage of the disease when treatment is first instituted. Reported figures from the University of Michigan give a 78% ten-year survival in stage 1 and a 12% ten-year survival in stage 4.

Treatment of Cancer of the Cervix

There are two acceptable methods of treatment of cancer of the cervix: (1) irradiation by means of high voltage roentgen rays and radium, and (2) radical surgical intervention. The latter must be truly radical (Wertheim). It is technically difficult and does not have more to offer the patient than properly applied radiation. A competent radio-therapist must apply the radiation.

Endometrial Carcinoma

Endometrial carcinoma constitutes about 15% of all female generative tract cancers. It occurs mainly in post menopausal women and is usually adenocarcinoma. A small freely moveable uterus implies less extensive involvement. Therefore the prognosis is better than in a larger uterus with fixation. The amount and histologic grade of the neoplasm are also important in determining the prognosis. Delays from onset of first symptom to beginning of treatment in endometrial carcinoma is approximately twice as long as in cervical carcinoma, i.e. 12 to 24 months.

Symptoms of Endometrial Carcinoma

The commonest symptom is spotting or bleeding with characteristics similar to those listed under cervix. Approximately 25% have a semipurulent leukorrheal discharge as their main complaint. About 5% have no symptoms, discovery being incidental.

Diagnosis of Endometrial Carcinoma

This is based on histologic confirmation of tissue obtained by curettage usually under anaesthesia. Suction curettage does not necessarily rule out endometrial cancer. Slight bleeding following bimanual is suggestive.

Not all irregular bleeding in adult women is due to cancer, but in every instance cancer must be suspected until proved otherwise. Bleeding from endocrine therapy does not recur on stopping the drug. In young adult women spotting may occur at time of ovulation. Cervical polyps and uterine fibroids must be considered in the differential diagnosis.

Treatment of Endometrial Carcinoma

The author favors preoperative use of irradiation, either high voltage roentgen or multiple capsule intracavitary radium, followed in 6 to 8 weeks by complete removal of uterus and adnexa in properly selected cases. Where operation is not feasible the first part of the treatment is favored.

Carcinoma of the Ovary

Carcinomas of the ovary constitute 10 to 20% of all cancers of the female reproductive organs. It is primarily a disease of post-menopause. The average age is 52. Diagnosis must be made histologically from the tumor tissue and this determines the prognosis. Clinical evidence alone is not sufficient to assess operability. Therefore every woman presenting a clinical picture of advanced carcinoma is entitled to exploration and biopsy.

Carcinoma of the Fallopian Tube

This neoplasm is rare, constituting 0.1% of cancers in above report. Most are of the papillary adenocarcinoma variety. They may be asymptomatic during their early development. Bimanual palpation may reveal a firm enlargement which cannot be accounted for on a basis of infection.

Conclusion

The author makes a special plea to the medical profession, and especially so to the general practitioner for periodic examinations every six months after the age of 40 years. The author appreciates the fact that many of the profession are already overloaded with caring for the sick but contends that it is serious neglect not to encourage periodic examinations. By so doing it is hoped that the mortality and morbidity from cancer can be substantially reduced.

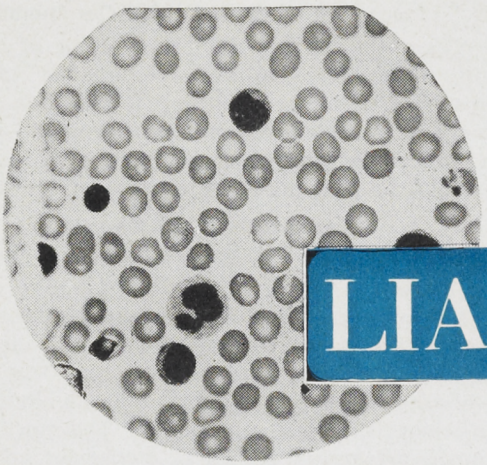
Discussion—J. D. McQueen

A good abstract of an excellent article written by an outstanding gynaecologist. In the main the management and treatment of carcinoma of the cervix and corpus uteri advocated by Miller is similar to that taught and practised locally. The results recorded are also similar though Miller's classification of groups or stages is one of his own and thus the results of treatment for individual groups may differ somewhat. The number of cases reported and completeness of the follow up is impressive.

Greater emphasis might have been placed upon the fact that in all cases of carcinoma of the cervix in Group 2 the parametrium must be considered to contain cancer cells and treated accordingly even though induration is not felt.

The abstract omits the important point made by Miller that malignancy found in one ovary demands the removal of both ovaries and uterus.

This abstract and the original article deserve the close study of all physicians.



When it is difficult to categorize the anemia

LIAFON

SQUIBB

DESICCATED LIVER
FERROUS SULFATE
ASCORBIC ACID
FOLIC ACID

A new hematinic combination for the simultaneous administration of *four therapeutic essentials*

DESICCATED LIVER: whole liver with only the water removed. Provides nutritive elements of fresh liver, including the experimentally essential, clinically impressive secondary anti-anemia fractions.

FERROUS SULFATE EXSICCATED: one of the most readily utilized, tolerated and absorbed forms of iron. For *specific treatment* of iron deficiency anemias.

ASCORBIC ACID: often a prerequisite in anemias associated with C avitaminosis. Recent work also suggests it influences iron absorption and red cell maturation.

FOLIC ACID: bone-marrow stimulant factor of the B complex, *specific* for macrocytic anemias of malnutrition, pregnancy, pellagra, and sprue; also of value with parenteral liver therapy in Addisonian pernicious anemia.

Thus, when more than one form of anemia is present or suspected, and is difficult to categorize, *Liafon provides the essentials for therapy.*

EACH LIAFON CAPSULE CONTAINS:	DOSAGE EQUIVALENTS 3 capsules daily	6 capsules daily
Desiccated Liver ..... 0.5 Gm. (Approx. equivalent to 2 Gm. whole fresh liver)	*6 Gm. fresh liver	*12 Gm. fresh liver
Ferrous Sulfate Exsiccated. 2.0 gr. (Approx. equivalent to 2.85 gr. ferrous sulfate)	*8.5 gr. ferrous sulfate	*17 gr. ferrous sulfate
Ascorbic Acid ..... 50.0 mg.	150 mg.	300 mg.
Folic Acid ..... 1.67 mg.	5 mg.	10 mg.

Liafon is supplied in bottles of 100 and 1,000

*Approximate equivalent

For Literature write

E. R. SQUIBB & SONS CANADA LIMITED
36-48 CALEDONIA ROAD • TORONTO

2245 Viau Street • Montreal

31-88

SQUIBB

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

General Practitioners

The American Academy of General Practice

L. A. Sigurdson, M.D.

About 12,000 doctors attended the 97th annual convention of the American Medical Association in Chicago this year. I represented the General Practitioners' Association of Manitoba as a delegate to the second annual meeting of the American Academy of General Practice*. Although the Academy is an autonomous body they have held both annual meetings at the same time and as a part of the program of the Scientific Assembly of the American Medical Association.

Organization

The organization meeting of the American Academy of General Practice was held in Atlantic City, New Jersey, on June 10, 1947. At this meeting 200 General Practitioners representing 31 States were present. Dr. Paul Davis, of Akron, Ohio, was Chairman and was subsequently made President. Other officers and a Board of Directors were then elected.

Groups from each State elected two members to represent them at the Congress of Delegates.

Enrollment

By June 15, 1948, the total enrollment of members in the Academy of General Practice was 4,645 It was hoped to build this number up to about 60,000 from the 100,000 General Practitioners in the United States.

Objects and Purposes of the Academy

The objects and purposes for which the Academy was formed are as follows:

"To establish an organization of general practitioners of medicine and surgery to promote and maintain high standards of the general practice of medicine and surgery;

To encourage and assist young men and women in preparing, qualifying and establishing themselves in general practice;

To preserve the right of the general practitioner to engage in medical and surgical procedures for which he is qualified by training and experience;

To assist in providing post-graduate study courses for general practitioners, and to encourage and assist practicing physicians and surgeons in participating in such training;

To promote the science and art of medicine and surgery and the betterment of the public health."

*Office located at 231 W. 47th Street, Kansas City 2, Missouri.

Dues

There is an initiation fee of $10.00 and the annual dues are $15.00.

Standing Committees

There are five standing committees constituted as follows:

(1) Membership
(2) Hospital
(3) Public and Professional Relations
(4) Education and Program
(5) Medical Co-ordination.

Meeting in June, 1948

The Congress of Delegates met in the Gothic Room of the Sheraton Hotel (the headquarters of the American Medical Association), on June 21, 1948. The President of the Academy called on me to be the first speaker at this meeting. I described the organization in Manitoba which I represented and stated the aims of the Association which are threefold.

"(1) To guard the rights of the public so that the service of the general practitioner, or family doctor, will not disappear.

(2) To guard the rights of the general practitioner so that the high standard of service will be maintained.

(3) To work in co-operation and harmony with all organizations of the medical profession."

My closing remarks were to the effect that "the quality of the practice in any community is the standard maintained by the general practitioner in that community."

Report of the Hospital Committee

The report of the hospital committee was read. The committee was of the opinion that "in order to promote better medical care for more of the people, hospital staffs in this country should recognize these facts and afford hospital privileges to all qualified general practitioners so they may, within their demonstrated abilities, perform professional services for their patients."

The Council on Medical Education and Hospitals of the American Medical Association have already adopted a resolution recommending that a Section or Department of General Practice be set up in each hospital.

A general practitioner was defined as "a physician and surgeon who does not limit his practice to any one field of medicine but practices in all fields, requesting consultation and assistance in situations beyond the scope of his ability or knowledge."

Since hospital staffs are dominated by the specialty groups the general practitioner has lost not

only prestige, but also the hospital privileges in many communities.

The American Academy of General Practice was the result of the complaints raised by the general practitioners on this important matter of exclusion from the hospitals in their communities.

Mr. Mac F. Cahal

The Executive Secretary and General Counsel of the Academy, Mr. Mac F. Cahal, is a man of outstanding ability. In his address to the Delegates he stated that many people considered that the general practitioner was one who could not get a hospital appointment and in any case was 20 years behind the times. With the newer drugs and anti-biotics the field of the general practitioner is gradually enlarging. Some surgical procedures such as blood transfusions are now done by the internes on the wards. The cost of medical care is becoming greater each year and increases in proportion to the specialization within the profession. Surveys have again and again revealed that the general practitioner can look after about 85% of cases. Psychosomatic medicine is particularly within the field of the general practitioner.

Dr. Eric A. Royston

The Chairman, Dr. Eric A. Royston, from Los Angeles, gave an address on "The Renaissance of the General Practitioner." Throughout the ages, from the savages to the men of today, the leaders have belonged to three groups, the clergy, the lawyers and the doctors. "The Family Doctor is the one to whom people have divulged their innermost secrets for ages beyond recall and from whom they have in return received the service they desired, regardless of what it cost him in time, money or loss of sleep."

Dr. Royston stated that as medical knowledge increased some doctors found it easier to limit their practices and to treat only certain diseases. Unfortunately, after these doctors commenced treating some particular part instead of the whole, some of them formed groups of their own and in a few years felt especially charged to control medical matters. They thus placed walls around the hospitals. They talked amongst themselves and occasionally to God.

He indicated that a new day was dawning with the formation of the Academy of General Practice. One of the immediate problems that the Academy is trying to solve is to see that all patients are treated alike in regard to admission to hospitals irrespective of whether the doctor is a general practitioner or a specialist. The general practitioner is the man who is in direct touch with the public, and is only asking to be allowed to continue to take care of his patients. This does not mean inferior service for the patient.

The general practitioner has the friendliest feeling for the specialist, admires him for his skill in a special field and wishes that he could be as proficient in each field, but Dr. Royston felt that the Specialists had made a mistake in entering the political arena.

Dr. Royston concluded his remarks by saying that "We must learn to hang together before a dictator hangs us separately."

Election of Officers

The following were elected to hold office for the ensuing year:

Dr. E. C. Lexter, President
Dr. Stanley R. Truman, President-Elect
Dr. J. P. Saunders, Vice-President
Dr. U. R. Bryner, Treasurer.

Doctors Davis, Boyd and Bibler were elected to the Board of Directors of the Academy. It was decided to hold the next meeting in Cincinnati in March next year, separate from the meetings of the American Medical Association.

Just as I was about to hand in this report to the Review, I received the following letter from Mr. Mac F. Cahal, General Counsel and Acting Executive Secretary:

"Belatedly, I want to take this opportunity to officially express the very great pleasure of the officers of the American Academy of General Practice in having you as our guest at the annual meeting of the Congress of Delegates in Chicago last month.

The brief addresses you presented to the delegates' meeting and again at the banquet that evening, were cogent and stimulating. We all enjoyed meeting you, and I sincerely hope I shall have the pleasure of seeing you occasionally in the years to come.

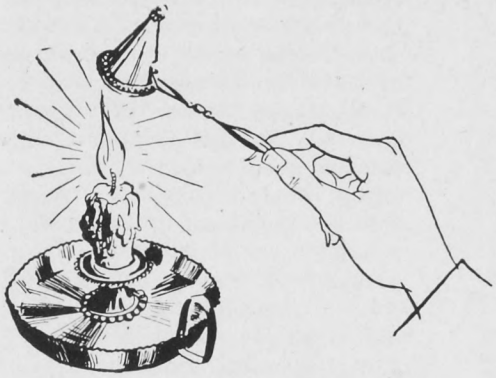
The first annual Scientific Assembly of the American Academy of General Practice will be held in Cincinnati, Ohio, March 7, 8 and 9, 1949. Naturally, we should be greatly pleased if some of our Canadian friends would come down for our first meeting.

I hope that in the course of time we will be able to affiliate the activities of the general practice folks in Canada with the program of the American Academy of General Practice. As you know, the By-laws of the Academy were amended at the recent meeting to permit medical organizations composed of general practitioners in Canada to become constituent chapters of the American Academy.

I shall see that you are placed on the mailing list to receive the regular publications and special material issued by the A.A.G.P. If there is ever any service I, or this office can render you, I hope you will not hesitate to call upon me.

Cordially yours,

(Signed) Mac F. Cahal."



Brief...

Brief too can be Nembutal's sedative action — and subject to your control. By adjusting the dosage to the need, any desired degree of cerebral depression — from mild sedation to deep hypnosis — can be achieved . . . And the required dosage is small—about *half* that of many barbiturates. Small dosage means less drug to be inactivated, reduced possibility of after-effect, shorter duration of effect, marked clinical safety and definite economy to the patient . . . Because short-acting Nembutal has such a wide range of sedative efficiency, its use is being extended to a wide variety of conditions—some 44 of which are listed at right. They may suggest enlarging your experience with Nembutal's reliable qualities . . . Your prescription pharmacy can supply you with any of eleven different Nembutal products, each in convenient small dosage forms.

In equal oral doses, no other barbiturate combines **quicker, briefer, more profound effect** than . . .

Nembutal

TRADEMARK REG'D

(Pentobarbital Sodium, Abbott)

Abbott

ABBOTT LABORATORIES LIMITED • MONTREAL

44 of Nembutal's clinical uses

Sedative

Cardiovascular
Hypertension[1] Decompensation
Coronary disease[1]
Angina[1]
Peripheral vascular disease

Endocrine Disturbances
Hyperthyroid
Menopause—female, male

Nausea and Vomiting
Functional or organic disease (acute gastrointestinal and emotional)
X-ray sickness Pregnancy
Motion sickness

Gastrointestinal Disorders
Cardiospasm[2] Pylorospasm[2]
Spasm of biliary tract[2] Colitis[2]
Spasm of colon[2] Peptic ulcer[2]
Biliary dyskinesia

Allergic Disorders
Irritability
To combat stimulation of ephedrine alone, etc.[3,1]

Irritability Associated With Infections[4]

Restlessness and Irritability With Pain[5,4]

Central Nervous System
Paralysis agitans Chorea
Hysteria Delirium tremens
Mania

Anticonvulsant
Status epilepticus Tetanus
Traumatic Eclampsia
Strychnine Anesthesia

Hypnotic

Induction of Sleep

Obstetrical

Nausea and Vomiting
Eclampsia
Amnesia and Analgesia[6]

Surgical

Preoperative Sedation
Basal Anesthesia
Postoperative Sedation

Pediatric

Sedation for:
Special examinations
Blood transfusions
Administration of parenteral fluids
Reactions to immunization procedures
Minor surgery

Preoperative Sedation

Nembutal alone or [1]Glucophylline and Nembutal, [2]Nembutal and Belladonna, [3]Ephedrine and Nembutal, [4]Nembudeine, [5]Nembutal and Acetylsalicylic acid, [6]administered with scopolamine or other drugs.

Medico-Historical

J. C. Hossack, M.D.

The History of Plague

In the litany of the Church of England there is a special prayer for deliverance from plague, pestilence and famine. I question if any part of that long supplication means less to the modern worshipper, but there was a time and that not long since when of all pleas it was the most fervent. Then plague, pestilence and famine were not mere words but stern realities. Like grim vultures they sat on each man's rooftree ever ready, ever threatening, to swoop and to slay. Nowadays plague and pestilence seem to play very minor roles among the ministers of death, but they have never been completely idle and no one can say when they will more actively arouse themselves.

Man very early became aware of plague and pestilence. He saw his world overwhelmed by their awful and mysterious visitations. Things so terrible struck fear into his soul and made him surer of the power of his gods; and, when he had devised a means of recording his thoughts and experiences, his earliest writings incorporated stories of these devastations.

The first description of a plague epidemic is to be found in the 1st book of Samuel in the fifth chapter where we read—"The hand of the Lord was heavy against them of Ashdod, and he destroyed them, and smote them with emerods, Ashdod and the coasts thereof." The prophet goes on to say how the disease spread to Gath and Ekron; how it smote men both great and small, how they "had emerods in their secret places," and how there was "deadly destruction" in these cities. The Philistines quickly realized that the plague was connected with their seizure of the Ark of the Covenant and "called for their priests and the diviners saying, What shall we do to the Ark of the Lord? And these answered and said, Make images of your emerods and images of the mice which mar the land and place them in a coffer by the side of the Ark and send it away." This was done but as the Ark passed through Beth-Shemish some curious people dared to look upon its sacred contents for which act of impiety "the Lord smote fifty thousand three score and ten men." Samuel lived about 1500 B.C. but even then the disease was old for when Moses led the Israelites out of Egypt and gave them laws, among the curses for disobedience we find "The Lord will smite thee with the botch of Egypt and with the emerods." Thus the disease was well known nearly 2,000 years before Christ.

Homer, who lived in the 12th century before Christ, opens the Iliad amid a scene of plague, again sent as punishment by an offended God upon an offending people. Apollo had been insulted in the person of his priest who invoked him thus—"O Smintheus, God of the silver bow thy shafts employ, Avenge thy servant and the Greeks destroy." The god thereupon "Twanged his vengeful bow, and hissing fly the feathered fates below." Then started a nine days' aerial blitzkrieg of such appalling effectiveness that the Greek chieftain was forced to sue for peace and make amends and thereby stop the plague.

It is interesting to note that Smintheus was the mouse god thus both in Samuel and in Homer plague is linked with rodents. The same association occurs in the story of the disaster which overtook the army of Sennacherib. That ancient exponent of the New-Old Order had left Hezekiah King of Judah trembling in anticipation of terrible happenings while he himself set out to destroy the Egyptians. But Isaiah assured his King that there was nothing to fear and sure enough "The Angel of the Lord went out and smote in the camp of the Assyrians an hundred four score and five thousand and when they arose early in the morning behold they were all dead corpses." It is Herodotus who brings the mice into the picture. Telling about the disaster he says that the Egyptian soldiers refused to fight whereupon their King besought the help of his god who answered the prayer by sending an innumerable army of field mice into the Assyrian camp. There the mice gnawed all the bow strings, the leather of the greaves and the straps of the shields so that next morning the Assyrians were helpless when the Egyptians fell upon them. Recent researches have shown that mice did have something to do with the affair and that the army probably perished of plague.

Sennacherib's misadventure occurred in 660 B.C. A century later we are reminded of its presence in Greece for it is in a plague-stricken city that Sophocles opens in his play "Oedipus Tyranus." "Oedipus, immortalized in psychoanalytic literature as the founder of a complex, had unwittingly committed incest. For this usurpation of a divine prerogative he had incurred the wrath of the gods and as was usual, 'for the King's offence the people died'." Again the plague was stayed in the usual way.

These early references to plague served chiefly to point a moral and adorn a tale. The first deliberate attempt to describe an actual epidemic was made by Thucydides when he recorded the plague that attacked Athens in 410 B.C. His description is vivid. He tells of the racking cough, the loath-

some eruptions, the burning fever which drove the sick and dying to the wells into which some fell out of exhaustion. He also relates the old prophesy thus fulfilled which the people remembered only when it was too late for them to retrace their steps. Thucydides does not mention buboes although such lesions were well known in his time for Hippocrates mentions them; and, as Thucydides was a careful observer it is likely that these swellings did not occur in the sick whom he described. From this it is inferred that the Athens epidemic was one of typhus. The ancients made no distinction between pestilential disorders but called them all "pestilence" or "plague" and the excellent description given by Thucydides was used by subsequent authors to describe contemporary epidemics. Despite the fact that such diseases played so important a role in history they are seldom commented upon unless of extraordinary severity. Yet forty times in the pre-Christian era they appeared in such devastating form that historians were compelled to record their occurrence.

The first epidemic recorded after the birth of Christ occurred in 166. It broke out in Italy whither it had been borne from Syria by the troops of Verus. It blasted a furious way across the continent taking such a terrific toll that, in the opinion of historians, the ancient world never fully recovered from its frightful assault. It slew half of the population of Italy and nearly all the soldiers. Marcus Aurelius was Emperor at the time, and being a philosopher (to whom all creeds were equally false, just as to the people they were all equally true) he called together all the priests of all the gods, foreign as well as native, Christian as well as pagan. But alas the gods had grown petulant. What was every god's business was no god's business. The pagans blamed the plague upon the tolerance of Christianity and the Christians blamed it upon the tolerance of paganism. None of the deities would stir and so deaths multiplied and terror increased. The doctors could not do much either and most of them, including Galen, testified to their own helplessness by taking safety in flight. The abomination of desolation fell upon Italy. Harvests withered in the fields, and the next year's increase was choked by weeds. Panic seized upon rich and poor and drove them to seek safety even in the very places from which others had just fled. Every where was demoralization. Scarcely had the nation rallied from this onslaught than it was overwhelmed by another during the reign of Commodus and then by still another during the time of Justinian. In this latter epidemic in the city of Constantinople alone there died from 5,000 to 10,000 daily for three months. It waxed and waned for half a century in which time it is credited with a hundred millions of deaths.

Probably the most terrible visitation of all was the Black Death. Into those two syllables is packed a world of terror, horror and despair. It is not possible to determine exactly the number of its victims but there can be no doubt of the terrible destruction that it wrought. It is supposed to have first shown itself in China in 1333 where it claimed 13,000,000 lives. In the rest of Asia and in Africa it took a further toll of 24,000,000. In Europe it slew between 25 and 40 millions. Death held high carnival the world over as plague staged it relentless progress. Wars were almost forgotten as the pestilence advanced. Returning soldiers slew more in peace than they had done in war—were more terrible by the hearth than they had been in the field. One of them, a Genoese, referring to the friends who met them on their return from the wars wrote "Woe unto us, for we cast at them the darts of death. Whilst they embraced us and kissed us we scattered the poison from our lips. Going back to their homes they in turn soon infected their whole families who in three days succumbed." War, disease and famine have ever been allies. "The sword is without, and the pestilence and the famine within. He that is in the field shall die with the sword and he that is in the city, famine and pestilence shall devour him, and shall destroy both the young man and the virgin, the suckling also with the man of grey hairs." Within a single month 40,000 died in Genoa, 60,000 in Naples, 70,000 in Sienna. Three-quarters of the Grand Council of Venice were slain. The Hotel Dieu of Paris sent for days together 500 dead to the cemeteries. The great suffered with the small. Countless noble families were exterminated. In England the King lost his daughter. Canterbury saw three Archbishops consecrated and dead within a single year. Many monastic communities were blotted out. Others were stripped to a single monk. The country over between 80 and 90 persons out of every 100 died of the Black Death. Flight was of no avail for the plague was everywhere. It emptied the cities, and villages were left tenantless save for the unshrouded dead which lay festering in their streets. Nor were the waters safer than the dry land. Plague showed itself upon the ships at sea. It slew the crews and no living thing was left but the rats and the germs of pest. These death-freighted derelicts drifted at the bidding of wind and wave until they were cast upon some far-off shore whither they bore their fatal cargo. Even worse than that barges were loaded with corpses and set adrift to go where fate took them.

The vast number of deaths created a problem. Individual burial was impossible. Even pits and trenches could scarcely be dug deep enough or fast enough to hide the ever increasing piles of

dead. In Avignon where the toll was 150,000 the Pope was led to consecrate the River Rhone so that its waters might be fit to receive what the earth could no longer hold. Guy de Chauliac, a native of Avignon, described the disease as he saw it. He wrote "During the first two months it was accompanied with a continuous fever and a spitting of blood. All who were attacked died in three days. During the other three months the fever was accompanied by boils which appeared in the external parts of the body chiefly in the armpits and the groins. Those who were thus attacked died in five days." Despite the hopelessness of the situation de Chauliac was active in treatment. He "comforted" the heart with pleasant viands such as treacle and apples. He "consoled" the humors by means of Armenian Bole, Galen's remedy. He purified the air with fires. He "ripened" the swellings with fig poultices and applied other equally ineffective measures.

The principal sufferers were the Jews. Not only did their habits render them particularly liable to infection but they also had to endure the superstitious hatred of their Gentile neighbours. In Strassburg 2,000 were driven into their own burial ground and burned alive. At Mayence 12,000 were put to death. In Basle all the Jews were collected in a building specially prepared for the purpose and burned in it. So intolerable was their plight that at Spiers and Eslingen in an excess of despair they gathered themselves in their synagogues and perished in flames of their own kindling.

It was prejudice that made the Jews the principal scapegoats: it was superstition and blind fear that led the people to attribute outbreaks to the practice called anointing. As enlightened a man as Paré believed that wicked people made pastes which incorporated discharges from victims of plague and that these pastes when smeared upon dwellings infected those who lived within. He writes: "What shall I add? They must keep an eye on certain thieves, murderers, poisoners, worse than inhuman, who grease and smear the walls and doors of rich houses with matter from buboes and carbuncles and other excretions of the plague-stricken, so as to infect the houses and thus be enabled to break into them, pillage and strip them, and even strangle the poor sick in their beds: which was done at Lyons in the year 1565, God! What punishment such fellows deserve: but this I leave to the discretion of the magistrates, who have charge of such duties." Ripamonte relates that while three French travellers were admiring the facade of a building, one of them touched the marble, was immediately set upon by a mob and dragged half dead to prison. An 80-year-old man, about to sit down upon a bench in church, wiped off the dust with his cloak. A woman cried out that he was anointing the benches and even there in the house of God the worshippers beat and kicked the life out of the unfortunate man.

Harsh indeed was the treatment meted out to those suspected of being anointers. Early one morning in June, 1630, during the prevalence of the plague in Milan, a woman from her window saw a man going down the street and writing upon a paper. He wiped his fingers upon the wall of a house probably to get rid of ink stains, but with the readiness of ignorance and fear, she was sure that he was smearing deadly ointments to promote the spread of the pestilence. A crowd of excited women invaded the Council Chamber and orders were given to trace out and arrest the guilty man. The scrivener was discovered to be a commissioner of health named Piazza. He stoutly denied all knowledge of the crime and maintained his resolution through two applications of torture, although the second one was the "question extraordinary." But in his cell, in the agonies of what was past and the dread of what was yet to come he confessed his "guilt" and declared that he had received the death-dealing ointment from a barber named Mora. The latter was immediately arrested but was likewise vehement in his declaration of innocence, avowing that he had never seen or known Piazza. But when put to the torture he broke down and confessed everything suggested to him. Indeed he went so far as to say that if his judges would tell him what they wanted him to say he would say it. In this way it was learned that between them they had gathered foam from the mouths of men dead of the pest and mixed this into an ointment.

The culprits having now admitted their guilt there was for them no escape. The Senate declared them both enemies of their country, decreed that, placed upon an elevated car, their flesh should be torn with red hot pincers, their right hands be cut off, and their bones be broken; that they should be extended upon the wheel, and at the end of 6 hours be put to death, and burned. Their property was to be sold and the house wherein the plot was hatched was to be razed to the ground and the ground strewn with salt.

As in previous epidemics physicians were of little service. "The malady seemed to set entirely at naught both the art of the physician and the virtues of physic." There was widespread belief in the virtues of aromatic plants. The doctors stuffed these into the beaks of the peculiar bird-like costumes they wore during the time of the epidemic. Certain herbs were also used in aqueous and alcoholic lotions. Paré gives a formula for such a "preservative water" with which the surgeon is advised to wash his whole body very frequently. He further advises "It is a good thing to wash the mouth with it and draw a little of it up the nose

and put a few drops into the ear. Paré tells of an instance when he narrowly escaped death from the contagion. He felt a sudden deadly syncope the result of the overpowering effluvia which arose from the buboes and carbuncles of a plague patient as he uncovered him. Upon regaining consciousness he sneezed violently ten or twelve times so that his nose bled and he attributed his escape to "virtue of the expulsive power of his brain seeing that all his other faculties were dead at the time."

The plague which struck Milan in 1660 found its way to England where it began to show itself in the autumn of 1664. The winter was cold whereby its spread was checked but by the end of April its presence was revealed in growing Bills of Mortality. As week succeeded week the numbers of plague victims increased until September when in the space of seven days 12,000 succumbed. Pepys, who stayed at his post in London, wrote in his diary (Aug. 30th) 'Abroad and went with Hadley, our clerk, who, upon my asking how the plague goes, tells me it increaseth much, and much in our parish: for, says he, there died nine this week though I have returned but six. Which is a very ill practice and makes me think it is so in other places."

Very many of the citizens fled the city so that the percentage of deaths was higher by reason of these flights. We are indebted to Pepys for much that went on in the sorely stricken city. He bore himself bravely and did good service to his country but found time to go about in his coloured silk suit, very fine, though he durst not wear his new periwig because the plague was in Westminster when he bought it and wonders what will be the fashion in periwigs when the plague is done for nobody dare buy hair for fear it had been taken from the heads of the dead.

It would seem that only upon the Assyrians did death come swiftly and quietly. Swift it remained but not silent. Roisterers, determined to die with the glass of pleasure in their hands, roamed the streets, caroused in taverns and drank to the unseen spectre in their midst. Their shouts, the wailing of the bereaved, the groans of the dying, the creaking of the dead carts, the tolling of the carters' bells, these furnished chorus and orchestra for this danse macabre.

Flight and fever in a few weeks had reduced the population of London by half. How many doctors normally attended its usual population we are not told, but there remained in the city to serve 240,000 inhabitants only 27. All the officers of the College of Physicians led by their President fled, to find on their return that the college had been broken into and the coffers emptied.

Among those who stayed was Alexander Burnett the medical attendant of Samuel Pepys. In making an autopsy upon a person dead of the disease he became infected and died. Francis Glisson (of Glisson's Capsule) worked energetically all through the epidemic. Thomas Wharton (of Wharton's duct) was for a while sorely tempted to flee when the plague broke out but he stayed to attend the large numbers of poor people who came to him at St. Thomas's Hospital. He also looked after the foot guards for which service he was promised the first vacant post as Physician-in-Ordinary to the King. But when a vacancy did actually arise he was put off with an augmentation in his coat of arms for which he had to pay £10 to the College of Heralds. Another physician who remained at his post was Nathaniel Hodges who wrote a book upon plague which gained him a Fellowship in the College of Physicians, but neither his services nor his reputation could save him from the Debtors Prison wherein he died. He has many bitter words to say about the nurses of the time. "These wretches," he says, "out of greediness to plunder the dead would strangle their patients and charge it to the distemper in their throats."

Another physician who remained was Daniel Defoe's friend, Doctor Heath, who "was of the opinion that the plague might be known by the smell of their breath; but then, as he said, who would durst to smell to that breath for his information." Defoe says also, "I have heard it was the opinion of others that it might be distinguished by the party's breathing upon a piece of glass, where the breath condensing there might living creatures be seen by a microscope, of strange, monstrous and frightful shapes, such as dragons, snakes, serpents, and devils, horrible to behold. But this I very much question the truth of."

There were many who held that the disorder was due to malign spirits but many more who saw in it an evidence of divine displeasure. Preachers of all sorts urged repentance upon the people as the only way to save their lives if they should sicken and their souls if they should die. Churches were crowded for many believed that therein they would be safe from the pestilence and that attention to religion would save their bodies. Not a few of these worshipers had much for which to repent and as the fury of the distemper increased men and women, crazed and disordered, went about the street crying aloud "I am a thief," "I am an adulterer," "I am a murderer" and yet attracting little attention even from enforcers of the law, so concerned was each one about his own safety.

Pamphleteers were not idle and a multitude of tracts, religious and otherwise were scattered, broadcast. One of these was entitled, "God's Terrible Voice in the City," and another had this to say: This contagious sickness called the pestilence is no other thing than a pressure, contagion

or whip which God, out of his indignation useth to chastise men for their transgressions. The pestilence is propagated and creepeth from one house to another by the breath heate, sweate, habitation and garments of the sick."

Most to be pitied were those who stood on the brink of parenthood. Women miscarried and died or they died with their offspring half born. Many a husband after vain search for a nurse or midwife had to deliver his dying wife of his dead child, even when he himself had the finger of death upon him. And those who had the ordeal yet to face shuddered as they heard the scriptural prophesy: "Woe be to those that are with child and to them that give suck in that day."

Whether it was because they believed the lies they told or because the hope of riches hardened them quacks increased in number and, so many physicians having fled, had the field of healing almost to themselves. And so, in the words of Defoe "It is scarcely to be imagined how the posts and house corners were plastered over with doctors bills and papers of ignorant fellows quacking and tampering in physic" and he gives an instance of the impudence of these imposters. "I cannot omit a subtlety of one of those quack operators, with which he gulled the poor people to crowd about him, but did nothing for them without money. He had, it seems, added to his bills, which he gave about the streets, this advertisement in capital letters, viz., 'He gives advice to the poor for nothing'."

Abundance of poor people came to him accordingly, to whom he made a great many fine speeches, examined them of the state of their health and of the constitution of their bodies, and told them many good things for them to do, which were of no great moment. But the issue and conclusion of all was, that he had a preparation which if they took such a quantity of every morning, he would pawn his life they should never have the plague; no, though they lived in the house with people that were infected. This made the people all resolve to have it; but then the price of that was so much, I think 'twas half-a-crown. "But, sir," says one poor woman, "I am a poor almswoman, and am kept by the parish, and your bills say you give the poor your help for nothing." "Ay, good woman," says the doctor, "so I do, as I published there. I give my advice to the poor for nothing, but not my physic." "Alas, sir," says she, "that is a snare laid for the poor, then; for you give them your advice for nothing; that is to say, you advise them gratis, to buy your physic for their money; so does every shopkeeper with his wares."

The Fire of London, in 1666, did not end the history of plague. Thereafter its ravages declined for it had consumed all those vulnerable to it but it did not cease. The East still felt its weight. From time to time the lambent flame flared up. In 1720 40,000 out of a population of 90,000 died in Marseilles and from that seaport it spread over France. In 1750 Constantinople which had suffered so often before suffered yet again when it mourned the deaths of 150,000 of its inhabitants. Twenty years later there was a time when in Moscow alone over a thousand died daily. In 1760 a rumor spread over London that the plague had broken out in St. Thomas's Hospital and next day the price of rue and wormwood had risen forty per cent. In 1799 Morocco was attacked with such fury that those left living were too few to bury the dead. In the same year Napoleon, retreating from Acre, was forced to order the poisoning of 580 of his sick soldiers to keep them from falling into the hands of the Turks. In 1834 Alexandria lost a third of its population. In 1900 it circled the world like a girdle. In 1925, in Los Angeles, there was an epidemic of some magnitude and, in a paper written in that year the author says, "We conclude that hundreds of millions, possibly billions, of human beings have lost their lives from plague—some 15,000,000 perhaps in the last three decades and there were a quarter of a million cases of the disease last year."

It would seem that everywhere the incidence of plague is on the wane yet no year passes without local outbreaks. Some of them — as the recent Cairo epidemic — of considerable severity. But while it is true that the disease has lessened among man and domestic rats it has nevertheless spread and is spreading among field rodents hitherto untouched. Where these animals come in contact with domestic rats there is possibility of wider spread and of future epidemics. Were the disease to become virulent among these newer hosts of the infection on any scale its control would be difficult and might even be impossible. Where famine no longer merely threatens and where whole populations are sapped of their vigor, their vigilance and their resistance, plague might well again stir from its dormancy and again intrude itself upon a weakened world. And if that time should come whither could men flee? Could modern medicine provide a stronger shield than medieval magic? Or would the people, despairing of help from man, again fling themselves upon their knees and cry "From plague, pestilence and famine good Lord deliver us."

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

The Convention

The Convention will be held next month but now is not too early to plan to attend it. The programme as it now stands you will find elsewhere in this issue. This particular Convention is likely to differ from such meetings in previous years because this year the matter of General Practice is likely to come in for discusion. During the past few months the City Practitioners have formed an association which, to be complete, requires the interest and the membership of rural practitioners. It is not a question of setting one group of doctors against another — than which nothing could be more hurtful—but to assure that each group will continue to enjoy what time has confirmed as their rights and privileges. Open discussion as well as open confession is good for the soul and the proper place for open discussion of medical problems is on the Convention floor. It is not enough to give private airing to grievances and dissatisfactions. If anything is to be accomplished such airing must be as thorough and in public. Then and only then are matters likely to receive proper attention and redress.

Medical History Section

For eighteen years there has existed, and at times flourished, a Medical History Section of the Winnipeg Medical Society. Lately its state has been the opposite of flourishing but I see no reason why we should not again become active. I have been agreeably surprised at the interest expressed by many readers in the papers on this subject which have appeared in the Review. Frankly they were put in merely as space-fillers and I scarcely hoped or thought that they would be generally pleasing. But as they have proved of interest it shows that the resuscitation of the Medical History section should not be difficult.

Therefore know all men by these presents that all ye who have interest in such matters are hereby required to set forth in writing that ye shall each of ye give one evening in the month to their discussion and that every man shall further promise to speak upon some matter that toucheth his interest, and that ye shall send these writings unto me at the earliest time possible so that our Section may speedily revive itself and prosper during the months to come. In other words sign up now and we shall have a full season of meetings.

Letters to the Editor

August 30, 1948.

Dr. J. C. Hossack,
Editor, Manitoba Medical Review,
Winnipeg, Manitoba.

Dear Dr. Hossack:

I would like to relate to you some experiences with one of our local hospitals.

On February 20, 1948, I saw a woman whose complaints suggested an acute cholecystitis. I was unable to get a hospital bed for her and asked a medical confrere to see what he could do. He was able to secure a bed for her and instructed them to phone me for orders. The hospital did not phone me; I phoned the hospital, contacted the ward, identified myself and attempted to leave orders. When I did this, I was asked to identify myself and was then informed there were no patients belonging to me on the ward. After explaining that Dr. ..... and I were jointly looking after the patient, I again attempted to leave orders, but was told the ward would not accept them. I then phoned Dr. ..... to have him leave orders. The investigation of the patient led to operation that night, when Dr. ..... and I removed an acutely inflamed gall-bladder. Throughout her stay in hospital the nurse refused all my orders and this, in spite of Dr..... 's request. This situation placed everyone in rather an embarrassing position, necessitating premature discharge of my patient from the hospital.

From October 16, 1947, to April 23, 1948, I attended a woman whose expected date was May 15, 1948. We arranged for her to go to the same hospital, I have heard nothing further from her since. She was admitted, as a private patient, to the hospital in question and delivered by one of the staff men.

In November of 1947, I attended a woman due to be confined about December 1, 1947, I last saw her in my office on November 26, 1947, at which time I arranged to have her notify me when her pains commenced. On December 8, 1947, having heard nothing from her, I contacted her home and found that my patient had been admitted and delivered at the hospital in question. I had not been notified of her admission to hospital.

I feel that this is a deplorable state of affairs. Repeatedly at medical conventions, equality of rights of physicians is stressed, yet nothing is done to correct such humiliating experiences by myself and others.

To the Editor:

Dear Sir:

Enclosed is an announcement inviting medical schools to make nominations for the 1949 group of Scholars in Medical Science. Dr. Marcel C. Blanchaer of the University of Manitoba Faculty of Medicine was appointed from Canada in the 1948 group.

The purpose of the program is to relieve in some measure the teacher-investigator shortage. Your help in making it known will be appreciated.

Sincerely yours, Dorothy Rowden.

Nominations for Scholars in Medical Science

Medical schools in the United States and Canada are invited by the John and Mary R. Markle Foundation to make nominations for the second group of Scholars in Medical Science on or before December 1, 1948. Each school, through the dean, may nominate one candidate. No nominations from individuals will be considered.

The program is designed to aid promising young men and women planning careers in academic medicine, who have not yet made their reputations. They should have completed the usual fellowship training in some area of science related to medicine and should hold, or expect to hold, in the academic year 1949-50 a full-time faculty appointment on the staff of a medical school.

Grants of $25,000, payable at the rate of $5,000 annually, will be made to the schools over a five-year period for the support of each Scholar finally selected, his research, or both.

The number of Scholars to be appointed in 1949 has not yet been determined. Sixteen were chosen in 1948. A new booklet describing the plan is available on request from the Foundation, 14 Wall Street, New York 5, N.Y.

Editorial from Bulletin of the Vancouver Medical Association

The following article appeared on the Editor's Page (Dr. J. H. MacDermot), of the Vancouver Medical Association Bulletin, Vol. XXIV, No. 9, Page 278, 1948: M.T.M.

At the recent Annual Meeting of the Canadian Medical Association, held in Toronto, there were two events which seem to us to have quite a far-reaching significance to the practice of medicine in Canada.

The first was the Lister Oration, delivered by that master surgeon of whom all Canadian medical men are justly proud, Dr. W. E. Gallie, of Toronto. He dealt with the modern trend in surgical education in the training of a surgeon, and, we take it, his remarks apply to the training of other specialists. It is quite a business, in these modern days. After the completion of his medical course, the would-be surgeon, to meet the requirements of the Royal Canadian College, must put in at least four and possibly five more years, before he can be regarded as a competent and fully qualified surgeon. These years are gruelling years of intensive study and training—going through internship, junior and senior residencies, and so on, till at last the finished product is released.

It is not our purpose to deny that this may, perhaps, ultimately be the right plan. But it is a very far cry from the process through which Dr. Gallie himself reached his present eminence as a surgeon. In the early part of his address he reminisced a bit, and gave us an anecdote or two of his own early beginnings. Unconsciously, he revealed some of the characteristics that led him to success, one was courage, and that peculiar type of courage, not untinged with a certain ruthlessness, and willingness to back one's own judgment, even though it means a bit of risk; that is, we think, an essential quality in the good surgeon—at least it has marked all the great surgeons we have known. Another is mechanical aptitude—the "hands" for the job; and nobody can deny that Gallie has this in full measure. Then there is judgment—surely based on long, hard-won experience and the ability to evaluate that experience—that can only come through years of practice. Again, all the great surgeons we have known have had that quality—almost intuitive it appears at first till one realizes that it is not intuition but experience on which they really rely. And there are other qualities of head and heart, of sympathy and understanding, that can only come through long contact with the sick and suffering, who put their lives and fortunes in the physicians' hands, and with them their faith and trust.

It is perhaps too soon to say that the new processes will not be as good—but one wonders nevertheless whether they will turn out as good men as the process which gave us a Gallie, or any of the other great names in medicine and surgery, whom we can all remember. Certainly they cannot do better.

The old way used to be to come to specializing through general practice. But if the new way is to be carried out as its present form would lead us to suppose, there will be no more of that. "Once a general practitioner, always a general practitioner" would seem to be the present slogan. The requirements for specialism are such that one cannot come back to them, after some years of general practice. If the young graduate wants to specialize, he must make up his mind before he leaves the training school.

There are many reasons why we think, ungenerously, that this is wrong. Some have been hinted at above. Another reason is the expense in time and money, the long, overlong, time that

one must put in at merely learning. If one could be guaranteed an immediate practice after this training, it might be worth while even then. But we see every day that men who have had this training and have their certificates, are forced by the exigencies of daily life to take up general practice, for a while at least, merely to make a living. Only the well-to-do or the lucky or the outstanding can arrive immediately at success in their specialty. Perhaps, from the public's point of view, this is all to the good—the public needs and clamours for general practitioners—but it surely reveals the fact that there is a flaw somewhere.

Might it not be better to combine the two ideas? To encourage general practice as a beginning, to be followed by special training and diversion into the chosen specialty? This would ensure a constant supply of men for general practice—thus fulfilling a very great and very real need. It would insure, too, that a man would choose a specialty for which he has found by experience that he was fitted by ability and temperament, and that his choice would have a basis of tempered judgment, rather than of glamour and perhaps even less worthy considerations.

The other event, the formation of a General Practitioners' Section as one of the regular sections of the Canadian Medical Association, somewhat emphasizes the points we have made. During the animated discussion that took place at the meeting, there was a demand for a return to the point of view that considers the main needs of the sick, the necessity for more and better general practitioners, the improvement of their status and of their standards of practice. This, we think, is a healthy sign, and a wise step has been taken. It is high time that we considered realistically the needs of the public, and stopped encasing ourselves in an ivory tower of specialism, which seems to be what we are rapidly doing. Such action on our part is bound to bring about reaction.

Public opinion and the necessities of the case, the rapidly increasing cost of medical care, all these will combine to bring about changes, some of which may not be to our taste. It is high time we put our own house in order—and we are glad to see that the first move in this direction has been made.

Pleasant "Salivary Analgesia"

White / LABORATORIES OF CANADA, LTD.

64-66 Gerrard Street, East, Toronto, Ont.

ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.

Manitoba Medical Association

(Canadian Medical Association, Manitoba Division)

ANNUAL MEETING

Royal Alexandra Hotel

October 19, 20, 21, 1948

TENTATIVE PROGRAMME

Tuesday, October 19th

9.00 a.m.—Registration.
10.00 a.m.—Scientific Session.
12.30 p.m.—Luncheon—Guest Speaker.
2.00 p.m.—Scientific Session.
6.30 p.m.—President's Dinner to Executive.

Wednesday, October 20th

9.00 a.m.—Clinical Session.
12.30 p.m.—Luncheon—Guest Speaker.
2.00 p.m.—Business Meeting.
8.00 p.m.—Business Meeting.

Thursday, October 21st

9.00 a.m.—Clinical Session.
2.00 p.m.—Scientific Session.
6.30 p.m.—Dinner—Dance.

Election of Officers and Executive Committee

In accordance with Article 11 of the Constitution and By-laws of the Manitoba Medical Association (Canadian Medical Association, Manitoba Division) the report of the Nominating Committee was presented to the Executive Committee and is reproduced below:

President:
Dr. H. S. Evans, Brandon.

First Vice-President:
Dr. D. L. Scott, Winnipeg.

Second Vice-President:
Dr. R. P. Cromarty, Brandon.
Dr. Eyjolfur Johnson, Selkirk.
Dr. C. W. Wiebe, Winkler.

Honorary Secretary:
Dr. A. M. Goodwin, Winnipeg.
Dr. J. E. Hudson, Hamiota.
Dr. Donald N. C. McIntyre, Winnipeg.

Honorary Treasurer:
Dr. Clare F. Benoit, Winnipeg.
Dr. C. B. Schoemperlen, Winnipeg.

Rural Member at Large:
Dr. E. K. Cunningham, Carman.
Dr. W. A. Howden, Neepawa.
Dr. A. S. Little, Dauphin.

City Member at Large:
Dr. L. A. Sigurdson, Winnipeg.
Dr. Anna E. Wilson, Winnipeg.

As provided in the same section other nominations may be made from the floor at the business session of the Annual Meeting, which will be held on Wednesday, October 20th.

Reproduced herewith is the:

CONSTITUTION AND BY-LAWS
of the
MANITOBA MEDICAL ASSOCIATION
(Canadian Medical Association, Manitoba Division)

Together with proposed revision which will be voted on at the Annual Meeting, October 19th to 21st.

♦

ARTICLE 1

Name

The Association shall be known as the Manitoba Medical Association (Canadian Medical Association, Manitoba Division).

ARTICLE 2

Aims and Objects of the Association

To enable the medical profession of the Province to fulfil, by co-operation and unified action, those responsibilities to society which its members cannot meet by individual action alone, specifically and especially:

1. To enlist and employ the moral influence of the united profession to maintain fair relations and equality of opportunity among its individual members.
2. To include and integrate as far as possible all other organized special groups in their proper relation to medicine as a whole, to help and coordinate their activities and mediate and harmonize their relations.
3. To help in the advance of all branches of medical service and to press for recognition of such attainment in proportion to its scientific and social value.
4. To maintain by moral influence the observance of professional etiquette in relations among its members, and to make such conformity a requirement for membership in the Association.
5. To initiate and support measures of public benefit where the scope of the individual member is restricted by the personal rules of the traditional ethical code.
6. To co-operate with humanitarian efforts to furnish medical service to the whole population and to press for the highest possible standard in such service.
7. To assist and support constituted authorities in matters within the field of medicine.

ARTICLE 3

Affiliated Societies

All societies or associations devoted to medicine or its allied sciences, including their constituent branches, sections or divisions, at present existing or which may hereafter be formed within the Province of Manitoba, may be regarded as component or affiliated groups of the Manitoba Medical Association, subject to their acceptance of such relationship, as defined by the Executive of the

Manitoba Medical Association and of its constitutional Aims and Objects, and of The Code of Ethics.

ARTICLE 4

Members

The membership shall be composed of:

1. Ordinary Members
2. Senior Members.
3. Honorary Members.
4. Members by Invitation.

Section 1—Ordinary Members

(a) Regularly qualified medical practitioners residing in the Province of Manitoba who pay the annual fee as determined by the Executive of the Manitoba Medical Association and subscribe to its Constitution, By-laws and Code of Ethics.

(b) Non-licensed persons wholly engaged in medical teaching or research in medicine may, on application and approval by the Executive of the Manitoba Medical Association, become ordinary members.

Section 2—Senior Members

Are those who, upon recommendation of the Manitoba Medical Association Executive, have been elected as Senior Members of the Canadian Medical Association. They shall have all the rights and privileges of the Association without the payment of any annual fee.

Section 3—Honorary Members

Any member of the medical profession or allied sciences who has become specially distinguished in his field of work may be elected an honorary member of the Association on nomination by the Executive. An honorary member shall be entitled to participate in all the proceedings of the Association, except voting, without contributing to its funds.

Section 4—Members by Invitation

Medical practitioners or distinguished scientists, non-resident in Manitoba, may be received as members upon invitation of the Association or its Executive. They shall hold their connection until the close of the meeting at which they are introduced and may participate in all the affairs of the meeting except voting.

ARTICLE 5

Officers

The officers of this Association shall consist of a President, First and Second Vice-Presidents, Honorary Secretary and Honorary Treasurer.

These officers shall be elected at the annual meeting, and shall enter upon their several duties as laid down by the by-laws at the conjoint meeting held at the close of, or immediately following the annual meeting at which they are elected. They shall hold office until the time of the conjoint meeting of old and new executives to be called after the subsequent annual meeting.

ARTICLE 6

Executive Committee

(a) The Executive Committee shall consist of the President, First and Second Vice-Presidents, Honorary Secretary, Honorary Treasurer and the two most recent Past Presidents; a Councillor elected by each of the District Medical Societies affiliated with the Association; two members appointed by the Council of the College of Physicians and Surgeons of Manitoba; the Health Officers' Association or other approved Associations that are autonomous and provincial in scope may each designate one representative to serve for one year; three members at large resident outside of Winnipeg and district and three members at large resident within Winnipeg and district.

At the joint meeting following the Annual Election, the members of the old and new Executive shall elect a member of the Manitoba Medical Association to act as Chairman of the Executive during the ensuing year.

Proposed Revision

ARTICLE 6 (a)

After: "College of Physicians and Surgeons of Manitoba."

Add: "One member of the Faculty of Medicine, University of Manitoba designated annually by the Faculty Council Executive of the Faculty of Medicine."

ARTICLE 6

Delete: "at the joint meeting following the Annual Election . . . to act as Chairman of the Executive during the ensuing year."

Representatives of District Societies

(b) Representatives of the affiliated District Societies shall be elected for a term of one year.

Members at Large of Executive

(c) Members at large shall be elected for a term of three years.

Vacancy

(d) The Executive may appoint a member to take the place of a vacancy upon the Executive until the next Annual Meeting, at which time a member shall be elected to complete the unexpired term.

Standing Committees

(e) The Standing Committees of the Manitoba Medical Association shall parallel the Standing Committees of the Canadian Medical Association.

The duty of each Chairman of a Standing Committee shall be to investigate and report to the Executive upon matters within the field of his committee or that may be referred to him by the Executive. A report in writing shall be made to the Executive when requested and also annually to the Association through the Executive.

The Nominating Committee shall consist of the President of the Manitoba Medical Association as Chairman, and one member from each District Society whose name shall be forwarded to the President at least six months before the Annual Meeting.

Proposed Revision

ARTICLE 6 (e) Paragraph 3

Changed to read:

"The Nominating Committee shall consist of the President of the Manitoba Medical Association as Chairman, the two immediate Past Presidents, and one member from each District Society, whose name shall be forwarded to the President on notification of the date of the meeting of the Committee."

(f) Special Committees may be appointed by the Executive to carry out special purposes. A majority shall form a quorum and they shall elect a chairman and secretary. They shall be discharged ipso facto as soon as the purpose for which they were appointed shall have been served. During the period of service of a special committee, the chairman shall attend Executive Meetings when notified by the Secretary. He shall be entitled to take part in discussion but shall not vote.

Proposed Revision

ARTICLE 6

Add Paragraph (g):

"The Manitoba Division shall nominate a representative and an alternate representative to the Executive Committee of the Canadian Medical Association each year. These nominees may be any members of the Manitoba Division and they shall be elected by the Executive Committee of the Manitoba Division at a meeting of the Executive prior to the Annual Meeting of the Canadian Medical Association. The representative of the Manitoba Medical Association on the Executive of the Canadian Medical Association shall be a voting member of the Executive of the Manitoba Division during his term of office."

ARTICLE 7

Funds and Appropriations

Every member shall pay the Treasurer or his accredited representative an annual fee of an amount to be determined.

The funds so raised shall be appropriated to defray the expenses of the Association, and for such other objects as may be deemed proper. Every member to pay an annual combined fee, which includes membership in the Canadian Medical Association and the Manitoba Medical Association.

ARTICLE 8

Duties of Officers

The President shall be concerned with the broad general policies of the Manitoba Medical Association and he shall be responsible for them under the direction of the Executive.

He shall preside at the annual and other full meetings of the Manitoba Medical Association.

He shall attend the meetings of the Executive Committee.

He shall, in consultation with the Chairman of the Executive, appoint Committees when so directed by the Executive.

He shall deliver an address at the annual meeting.

He shall sign all orders for payment of money drawn on the Treasurer by the Secretary.

He shall call a conjoint meeting of the retiring and the newly elected Executive Committees at the close of or immediately following the annual meeting.

The President shall be ex-officio a member of all committees.

The First Vice-President shall, in the absence of the President, perform his duties, and in his absence the Second Vice-President shall act.

The SECRETARY shall attend all the meetings of the Association, with the records, documents and papers belonging thereto. He shall record and authenticate the published transactions and essays belonging to the Association, and perform such other duties as may be required of him by the Association or President. He shall be ex-officio a member of all committees.

Proposed Revision

ARTICLE 8

Paragraph 4, Delete:

"in consultation with the Chairman of the Executive."

Paragraph 6, Add:

"or delegate such duty to the First Vice-President."

Add at end:

"The **Executive Secretary** shall be appointed by the Executive Committee and shall remain in office at the pleasure of the Executive Committee. He shall receive such salary and expense funds as may be decided by the Executive Committee. He shall carry out such duties as are assigned to him by the President and Honorary Secretary and Executive Committee. He shall be a member ex-officio of all committees. He shall have no voting power in the Association."

ARTICLE 9

Duties of Executive Committee

The Executive Committee shall be the responsible agent of the Association for the transaction of its affairs; it shall direct and integrate the work of all committees and shall promptly report the proceedings of each meeting to the affiliated District Societies and submit a comprehensive report at the Annual Meeting.

It shall decide what acts of the Association are to be included in the record of Considered Decisions and shall be responsible for the publication of the scientific papers of the Association.

During the year the Executive shall appoint a firm of accredited auditors.

Acting under the Executive and the President, the Chairman of the Executive shall be the active administrative officer of the Manitoba Medical Association.

He shall decide the agenda for the Executive Meetings.

He shall preside at the Executive Meetings at the will of the President.

He shall attend the meetings of the Standing Committees.

He shall be responsible for seeing that the work and reports of all committees are rendered when due.

He shall integrate all committee work and reports and prevent overlapping and incoherence.

He shall direct the activities of the paid officials of the Manitoba Medical Association.

He shall consult the President and accept his direction upon all matters of general policy.

He shall take the initiative in selecting and recording, subject to the approval by the Executive, those matters of general policy that should be classed as "Considered Decisions."

Proposed Revision

ARTICLE 9

Delete: All reference to the Chairman of the Executive Committee and his duties from "acting under—to—as considered decisions."

ARTICLE 10

Duties of the Treasurer

The TREASURER, or his accredited representative, shall collect the dues and demands of the Association from the members, and the Treasurer shall hold the same in trust for the Association.

The Treasurer and his accredited representative, if any, shall be bonded at the expense of the Association.

He shall at every annual meeting, or oftener if required by the President, present his accounts, with the vouchers, duly audited and signed by the Auditors, and at the end of his term of office shall hand them to his successor or the President of the Association, together with the money, books and other property belonging to the Association.

He shall pay such orders as may be drawn on him by the Secretary, countersigned by the President.

All accounts for payment shall be signed by the President or Vice-President and Honorary Secretary, and cheques shall be signed by any two of the following: Treasurer, President, Vice-President and Honorary Secretary.

ARTICLE 11

Election of Officers and Executive Committee

The President, First and Second Vice-Presidents, Honorary Secretary, and Honorary Treasurer, and the additional members of the Executive Committee, unless otherwise provided in this constitution, shall be elected at the business session of each annual meeting. They shall be elected from nominations to be submitted by the Nominating Committee to the Executive Committee at least two months before and published in the Association Journal at least one month before the Annual Meeting, and from such other nominations as may be made from the floor at the business session of the Annual Meeting.

Proposed Revision

ARTICLE 11, Election of Officers and Executive Committee

Change to read:

The President, First and Second Vice-Presidents, Honorary Secretary, and Honorary Treasurer, and the additional members of the Executive Committee, unless otherwise provided in this constitution, shall be elected at the business session of each Annual Meeting. They shall be elected from nominations, one or more names for each office, to be submitted by the Nominating Committee to the Executive Committee and published in the Association Bulletin at least one month before the Annual Meeting, and from such other nominations as may be made from the floor at the business session of the Annual Meeting.

The voting shall be by ballot. The poll shall be open during the Annual Meeting for such period after nominations are closed, as shall be decided by the President.

ARTICLE 12

Meetings

The regular meetings of the Association shall be held annually at such time and place as may be determined by the Association at its previous annual meeting, in default of which the time and place shall be fixed by the Executive.

Fifteen ordinary members shall constitute a quorum for the transaction of business at any annual or special meeting.

Special meetings shall be called by the President upon a written requisition stating the objects of such meeting, signed by ten ordinary members.

Proposed Revision

ARTICLE 12

Add after Paragraph 3:

"At any regular or special meeting of the Association the President may declare, or the majority of the members in session may rule that any motion shall be voted on by ballot and then the President shall declare the manner of balloting and the period the poll for such balloting shall be open."

ARTICLE 13

Order of Business

The following shall be the order of business at the regular meetings of the Association, unless otherwise ordered by the Executive. The ordinary parliamentary rules shall govern the transaction of business during the meeting.

(a) General Sessions:

1. Calling the meeting to order.
2. Reading of addresses and papers.

(b) Business Session:

1. Calling the meeting to order.
2. Minutes of last meeting.
3. Communications.
4. Nominations.
5. Report of the Executive Committee.
6. Report of the Treasurer.
7. Reports of Committees including the Resolutions Committee.
8. Elections.
9. Unfinished Business.
10. New Business.
11. Adjournment.

ARTICLE 14

Members and Their Duties

Papers and addresses presented at meetings become the property of the Manitoba Medical Association and a copy shall be given to the Secretary to be preserved by him in the records of the Association.

No person eligible for membership in the Association who is not a member thereof shall be permitted to address the Association.

ARTICLE 15

Amendments

Any proposal for amendment or addition to the Constitution or By-laws must be given in writing to the Honorary Secretary at least one month before the annual meeting, and must be laid by him before the Executive Committee and sanctioned by a two-thirds vote of the members present before it is submitted to the Association.

Proposed Revision

ARTICLE 15

Be changed to read:

"Any proposal for amendment or change of the Constitution or By-laws of the Association shall be given in writing to the Secretary at least one month before the next Annual Meeting of the Association. It shall be laid by him before the Executive Committee for consideration and reported by it to the Annual Meeting, when same will become an amendment by majority of votes of members present. Should any proposal for amendment or change of the Constitution or By-laws of the Association not be submitted to the Secretary one month before the Annual Meeting, but submitted at Annual Meeting, before becoming effective it must obtain at least three-quarters of the votes of members present."

ARTICLE 16

Code of Ethics

The code of ethics of this Association shall be that adopted by the Canadian Medical Association.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA

(Continued from July Issue)

Council Meeting

A special meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Wednesday, May 19th, 1948, at 2 o'clock p.m., in the Medical College, Winnipeg.

The President, Dr. W. F. Stevenson, called the meeting to order.

The business of the meeting was as follows:

Roll Call. The following members were present: Doctors W. F. Stevenson, President; C. B. Stewart, Vice-President; T. H. Williams, Treasurer; M. T. Macfarland, Registrar; A. A. Alford, B. D. Best, C. S. Crawford, E. K. Cunningham, Edward Johnson, J. M. Lederman, I. Pearlman, J. S. Poole, J. Prendergast, F. A. Rybak, D. L. Scott and C. W. Wiebe.

A letter of regret was received from Dr. W. S. Peters.

Greetings were received from Dr. W. G. Campbell.

Mention was made of the death of Mrs. H. Bruce Chown, wife of the member of Council, and the fact that a floral contribution had been sent to the funeral.

The President announced that nine members of the College of Physicians and Surgeons of Manitoba had died since the last meeting of Council on October 15th, 1947.

A period of silence was observed in memory of these doctors.

Minutes. The Registrar announced that each member of Council had received a copy of the minutes of the Council meeting held October 15th, 1947.

Motion: "THAT the minutes of the Council Meeting held October 15, 1947, be accepted as read." Carried.

Resignation of Dr. W. S. Peters

A letter dated May 17th, 1948, was presented from Dr. W. S. Peters, announcing his resignation from the Council owing to ill health.

Motion: "THAT this Council accepts with regret the resignation of Dr. W. S. Peters, and that the Registrar proceed to arrange a by-election in the constituency of Brandon." Carried.

Business Arising From the Minutes of the Council Meeting Held October 15th, 1947

Marriage Act. Each member of Council had been presented with a copy of the amendments to the Marriage Act at the meeting of Council on October 15th, 1947. The amendments were approved.

Temporary Register. The Registrar reported that to-date 13 temporary licences had been issued, 6 to Provincial Government employees, 4 to Federal Government employees, one of which had been cancelled and a permanent registration certificate issued, 2 to members of the Armed Forces, and 1 to a graduate hospital interne.

The Council decided:

(i) That temporary licences issued to employees of the Federal or Provincial Government are not renewable, and at the end of the first twelve months of employment they should become permanently registered, or the licence be cancelled.

(ii) That members of the College with temporary licences would not be eligible to vote in the 1949 election.

(iii) That in view of the amendments to the Medical Act, the Registrar be authorized to advise all unregistered doctors in the Province that they should become registered.

(iv) That employees of the Sanatorium Board of Manitoba are eligible for temporary licence, for the first 12 months of employment.

(v) That a temporary licence would cover a doctor taking a three-year course at Deer Lodge Hospital only during the first 12 months of his employment at the Hospital, and that if he took a locum tenens, he would have to be registered permanently, as there is no provision for temporary licensing of locum tenens.

(vi) That a doctor taking a three-year course towards his fellowship, and during his course spends a 6-month preceptorship with another doctor, would be covered by a temporary licence during his three years training.

The Registrar explained that there were four types of employees at Deer Lodge Hospital. Junior Internes earning the minimum of $1,080 per year; Senior Internes earning the minimum of $1,800 per year; Assistant Residents earning the minimum of $2,700 per year, and Residents earning the minimum of $3,300 per year. He inquired whether the junior interne should be classified as a graduate hospital interne, and charged the fee of $5.00 for temporary licence.

Motion: "THAT the Junior Interne, D.V.A., be assessed $5.00 for a temporary licence, and that Senior Internes, Assistant Residents and Residents, D.V.A., be assessed $10.00 for a temporary licence." Carried.

Letter of Thanks. A letter was read from the Chairman of the Local Finance Committee, Canadian Medical Association, thanking the Council of the College of Physicians and Surgeons for assuming full responsibility for the total deficit

involved in entertainment in connection with the C.M.A. Convention held in Winnipeg in June, 1947.

Letters were also presented from the Manitoba Medical Association and the Winnipeg Medical Society, expressing their appreciation.

Reports of Standing Committees and Their Consideration

Executive Committee. The Registrar stated that each member of Council had received a copy of the minutes of the Executive Committee meeting held February 17, 1948.

Motion: "THAT the minutes of the Executive Committee meeting held February 17, 1948, be taken as read." Carried.

Business Arising From the Minutes of the Executive Committee Meeting Held February 17, 1948

Winnipeg Medical Society Benevolent Fund.

Dr. Ross Mitchell, Chairman of the Winnipeg Medical Society Benevolent Fund, appeared before the Council. He outlined the aims and objects of the W.M.S. Benevolent Fund, and suggested that the College contribute annually a sum equal to that raised by contributions from members of the Winnipeg Medical Society.

After considerable discussion, the following motion was passed:

Motion: "THAT as the Winnipeg Medical Society Benevolent Fund is a local affair, the College of Physicians and Surgeons of Manitoba is unable to contribute towards it." Carried.

Reinstatement, Medical Council of Canada

. . . . . .

The Registrar was asked whether Dr. ..... would be eligible for reinstatement and whether he would have to write the examinations of the Medical Council of Canada. Dr. Macfarland wrote to Dr. J. Fenton Argue, Registrar of the Medical Council of Canada, and the following reply was received:

"In cases such as this, the Medical Council of Canada generally waits until the province in which the physician was convicted restores him to their register. Then, generally our Council reinstates him following similar action by the licensing board involved. Dr. ..... will not have to re-write any examinations."

. . . . . .

Dr. ..... stated that at the last meeting of the Medical Council of Canada three men were struck off the register. The minutes read that when Dr. ..... was readmitted to the College of Physicians and Surgeons of Manitoba, he would be readmitted at Ottawa. He stated that neither he nor Dr. ..... had any recollection of such a motion being passed. He understood that they could not be reinstated with the Medical Council of Canada without writing their examinations. He stated that the question would arise at the next meeting in September.

Results of the By-election in South Winnipeg

The Registrar announced that Dr. D. L. Scott had been elected the representative to the Council of the College of Physicians and Surgeons of Manitoba from the constituency of South Winnipeg.

The Registrar stated that there were 346 physicians in South Winnipeg, of which 332 were eligible to vote. There were 63 nomination papers returned, and 34 names nominated. 30 accepted nomination, and 203 voting papers were returned.

Disposal of Ballots

Motion: "THAT all voting papers be destroyed." Carried.

Payment of Scrutineers

Motion: "THAT the scrutineers be paid Six Dollars and Twenty-five Cents ($6.25) for their services." Carried.

Proposed Legislation. (See Committee of Fifteen).

Fees

In connection with life membership on reaching the age of 65 and practising 30 consecutive years in the province, the Council were of the opinion that if a man leaves the province to do post-graduate work, he should have the privilege of paying the fee for the year he was absent, thereby making him eligible for life membership.

The Registrar reported that he had been approached regarding exclusion from fees for veterans of the 2nd World War. He said that there were approximately 122 doctors who would be eligible. The matter was tabled.

The Registrar reported that there were 26 members in arrears of their annual fee, of that number 3 were in arrears for more than the current year.

Interneship Year

At the Executive Meeting, February 17, 1948, a letter from Dr. J. Fenton Argue, enclosing a letter from Dr. H. H. Hepburn, Chairman of the Educational Committee, Medical Council of Canada, re coincidental examinations and interneship year, was presented. Since that meeting, the Registrar reported that he had received a letter from the Registrar of the College of Physicians and Surgeons of Alberta, stating that a resolution passed at the meeting of the Registrars in June, 1947, was being strictly adhered to in Alberta. This resolution stated that no Enabling Certificates be granted until such time as the applicant had completed one year's interneship, graduate or undergraduate, in a hospital approved for interneship. Dr. Bramley-Moore also stated in his letter that applicants for licensure must also submit proof of interneship. He inquired whether Manitoba granted Enabling Certificates without interneship, or whether licences to practice were granted without interneship.

The Registrar replied that the Council had not taken any formal action to endorse the principle of requesting proof of interneship, but that the Registration Committee were of the opinion that the standard should not be lower than that required for Manitoba students, which includes one year undergraduate interneship.

The Registrar also reported that he had a verbal communication with a member of the committee of the Faculty of Medicine, studying changes in the medical course, making premedical course 3 years, and granting B.A. degree in 2nd year medicine, and M.D. at the end of 4th or 5th year, depending on whether interneship is under or postgraduate.

Dr. .....stated that the premedical course increase to 3 years in the Faculty of Arts and Science had been approved by the Faculty of Medicine and the Senate of the University, to go into effect probably in the 1949-50 session. The difficulty up to the present had been that premedical education had left students, not accepted for Medicine, unable to go on to a degree. The extra subjects would be partly cultural subjects, and the students would take regular classes in physics and chemistry rather than the compressed course. They would only require to take one more year to get an arts and science degree, instead of two years at present, plus some summer school to make up deficiencies in the course already taken.

The Registrar inquired if the Council was willing to commit itself to one year of interneship prior to the issuance of an Enabling Certificate and/or registration, in view of the study that is being made.

After considerable discussion as to whether the interneship year should be postgraduate or undergraduate, the Council were of the opinion that before expressing a definite decision the matter should be given further study.

Motion: "THAT the Education Committee make a detailed study of this matter, and report at the October Meeting of Council." Carried.

General Medical Council of Great Britain

The Registrar presented a letter from the Registrar of the General Medical Council of Great Britain, advising that practitioners temporarily registered by virtue of Defence Regulation 32B or of section 5 of the Polish Resettlement Act, 1947, are eligible to apply for registration under the Medical Practitioners and Pharmacists Act, 1947. The letter stated that the Colonial List had been changed to Commonwealth List. He also requested that he be kept informed of any practitioners temporarily registered in Great Britain, who indicate a desire to migrate to Canada.

The Manitoba Cancer Relief and Research Institute

As instructed by the Executive Committee, the Registrar reported that the President and Registrar of the Council of the College of Physicians and Surgeons of Manitoba, are the only representatives to the Institute.

Registrars' Meeting

The Registrar reported that he had received word from the Registrar of the College of Physicians and Surgeons of Ontario, who is arranging the meeting of the Registrars in Toronto in June, advising that the Presidents of the various Colleges were also being invited. Dr. Stevenson stated that he had received his invitation. The Registrar stated that the problem of foreign graduates was a matter of prime importance to be discussed by the Registrars, and Dr. Noble had requested that each Registrar bring with him a list of the applicants from European schools.

Motion: "THAT the Treasurer be authorized to pay the Registrar's expenses during the trip to Toronto to attend the meeting of the Registrars." Carried.

Registration Committee

The Registrar stated that each member of Council had received a copy of the minutes of all Registration Committee meetings held since October, 1947.

Motion: "THAT the minutes of the Registration Committee be taken as read." Carried.

Reciprocal Relations With Other Medical Boards in Australia

The Registrar advised that the College of Physicians and Surgeons of Manitoba had reciprocity with New Zealand, and New South Wales, Australia. He stated that correspondence had been carried on with the other medical boards in Australia, but that nothing had been done since 1944.

Motion: "THAT a further effort be made to arrange reciprocal relations with the remaining medical boards in Australia." Carried.

Medical Student Registration in the University of Manitoba Calendar

The Registrar announced that there was no mention of medical student registration in the Faculty of Medicine Calendar of the University of Manitoba. He stated that he had spoken to the Dean concerning the changes which should appear in the Medical Calendar in line with the amendments to the Medical Act, but at that time the calendar for 1948-49 was in the hands of the printers.

Motion: "THAT arrangements be made to have the necessary changes made in the University of Manitoba Medical Faculty calendar." Carried.

Foreign Graduates

The Registrar stated that there were two resolutions on the books of the College in connection with foreign graduates:

The first one passed by Council on October 19, 1938, is as follows:

"THAT the Council of the College of Physicians and Surgeons of Manitoba is opposed to the granting of registration to others than graduates from Canadian Colleges.

"For registration in Manitoba, the applicant must be English or French speaking, and each foreign application must be considered individually and specially.

"Our reciprocal relationship with Great Britain, and our cordial relationship with the United States, does not permit the receiving of numerous foreign applications."

The second one passed by Council on October 17, 1945, is as follows:

"WHEREAS the College of Physicians and Surgeons of Manitoba is receiving a number of applications for enabling certificates and licences, from graduates of continental colleges;

"AND WHEREAS it is now felt by this Council that the sphere of greatest usefulness for these men is in the countries from which they originally came; it is therefore resolved:

"THAT their applications for licences and enabling certificates in the Province of Manitoba be not considered."

The following exception is made to the above resolution:

"WHEREAS there have been employed for a period of time by the Manitoba Government, graduates of various continental universities, and these men are now applying for enabling certificates and licences in Manitoba, it is resolved:

"THAT they be asked to attend the Medical College for one year, and to pass fourth year examinations as laid down by the University of Manitoba. If this is complied with, then an enabling certificate may be granted to these men."

The Registrar explained that at the time of the second resolution, there were four European doctors in the province, working for the Government, but that they had all taken their credentials and left the Province. He stated that since that time there had been several applications received from foreign graduates requesting to have their credentials established in Manitoba, five of them being in the Province at the present time. He said that the Senate Committee of the University of Manitoba who issue the Basic Sciences Certificates of Credit were unable to assess the qualifications of foreign doctors. When questioned as to what stand the other provinces were taking, the Registrar stated that they were having the same difficulty. He said that Ontario requires Canadian or British citizenship, which takes 5 years. Quebec hesitates to take them at all. Saskatchewan requires them to serve one year in hospital under supervision, obtain statements from the supervisors, and then write the examinations of the Medical Council of Canada. He stated that this question would be discussed at the meeting of the Registrars in June.

After considerable discussion the following motions were passed:

Motion: "THAT the first paragraph of the resolution passed October 19, 1938, reading:

" 'THAT the COUNCIL of The College of Physicians and Surgeons of Manitoba is opposed to the granting of registration to others than graduates from Canadian Colleges,' be rescinded." Carried.

Motion. "THAT the portion of the resolution passed October 17, 1945, reading:

" 'WHEREAS the College of Physicians and Surgeons of Manitoba is receiving a number of applications for enabling certificates and licences from graduates of continental colleges;

" 'AND WHEREAS it is now felt by this Council that the sphere of greatest usefulness for these men is in the countries from which they originally came; it is therefore resolved:

" 'THAT their applications for licences and enabling certificates in the Province of Manitoba be not considered,' be rescinded." Carried.

The Council were of the opinion that there should be a uniformity of policy throughout the Dominion.

Motion: "THAT no action be taken at the present time, and that the matter be deferred to the October meeting of Council, when the Registrar could report on the decisions of the Registrars' Meeting." Carried.

Education Committee

The Registrar reported that each member of the Council had received a copy of the minutes of the Education Committee meeting held February 17, 1948.

Motion. "THAT the minutes of the Education Committee meeting held February 17, 1948, be taken as read." Carried.

Finance Committee

The treasurer reported that a meeting of the Finance Committee had been held at 1.00 p.m. that date, and the following resolutions were presented:

"THAT the sum of Four Thousand Dollars ($4,000.00) be transferred from Current Account to Investment Trust Account." Carried.

"THAT Dominion of Canada 3% fully registered bonds to a total of Five Thousand Dollars ($5,000.00) be purchased from surplus funds in the Investment Trust Account." Carried.

Motion: "THAT the action of the Finance Committee be confirmed." Carried.

Legislative Committee. (See Committee of Fifteen).

Discipline Committee

The Registrar reported that each member of Council had received a copy of the minutes of the Discipline Committee meeting held February 17, 1948.

Motion. "THAT the minutes of the Discipline Committee meeting held February 17, 1948, be taken as read." Carried.

Business Arising From the Minutes of the Discipline Committee Meeting Held February 17, 1948

Complaint against Dr. ..... from Mr. .....

The Registrar reported that he had been instructed by the Discipline Committee to obtain a further report from Dr. ....., and he presented a letter dated April 7, 1948, outlining the history of the case.

Motion: "THAT no action be taken." Carried.

Complaint against Dr. ..... from Mr. .....

The Registrar reported that he had been instructed by the Discipline Committee to obtain further statements from Dr. ..... and Dr. ..... He presented a letter dated March 5, 1948, from Dr. ..... explaining his actions in the case, and a letter dated May 11, 1948 from Dr. ..... outlining his history.

Motion: "THAT no action be taken." Carried.

Disciplinary Proceedings of the Colleges of Physicians and Surgeons of Alberta and Saskatchewan

The Registrar presented the Saskatchewan Medical Quarterly for December, 1947, and April, 1948, the Alberta Medical Bulletin for October, 1947, and the British Medical Journal for April 26, 1947, in which were outlined details of disciplinary action of these medical boards.

Motion: "THAT the Discipline Committee study these reports and present their findings to the Council Meeting in October." Carried.

Reports of Special Committees and Their Consideration

Representatives to the M.M.A. Executive. The Registrar reported that with the resignation of Dr. W. S. Peters, one of the Council's representatives to the Manitoba Medical Association Executive, it would be necessary to appoint another member in his place to complete the term.

Motion: "THAT Dr. Edward Johnson be appointed a representative of the Council of the College of Physicians and Surgeons of Manitoba to the Manitoba Medical Association Executive." Carried.

Representatives to the Committee of Fifteen. The Registrar reported that the Committee of Fifteen, and Chairman of the Legislative Committee, met with Dr. F. W. Jackson, Deputy Minister of Health, on February 26, 1948, when Dr. Jackson outlined the proposed legislation. There were amendments to the Vital Statistics Act, the Health and Public Welfare Act, the Marriage Act, the Hospital Aid Act, the Public Health Act, the Tuberculosis Control Act, the Health Services Act, none of which were controversial.

It was not felt advisable to amend the Basic Sciences Act regarding the granting of Certificates of Credit to holders of the L.M.C.C., and registrants of the General Medical Council of Great Britain, and it has since been dealt with by Order-in-Council.

He stated that at the time of the meeting there were two proposed private bills, one to license Opticians, and one to license Physio-Therapists and Massage Practitioners. The Opticians' bill was withdrawn, but the Physio-Therapists' bill went to second reading. The Registrar stated that he consulted the solicitor and asked him to protect the interests of the C.P. & S., and the M.M.A. He said that there was no reference, as in the British Columbia bill, of which the Manitoba bill was supposed to be a copy, of the fact that the Physio-Therapists would work under the supervision of the Medical Profession. He stated that the bill was opposed by the Canadian Physio-Therapy Group, which have higher standards than the local group. The bill was withdrawn.

The Registrar was then informed by Dr. Jackson that an amendment would be made to the Public Health Act, "providing for the licensing of any persons whose business or operations has anything to do with the practice of the healing art as defined by the Basic Sciences Act, and, without limiting the generality of the foregoing, shall include the licensing of opticians, masseurs and physio-therapists and other auxiliary medical and dental personnel." Such an amendment would have weakened the Basic Sciences Act.

Bill 79 was presented and passed at the last session of the Legislature. Bill 79 dealt simply with License of Opticians, Masseurs and Physio-Therapists. For Physio-Therapists a board of 5 will be set up to draw regulations, consisting of 1 representative from the Canadian Association of Physio-Therapists, 1 from Manitoba Association, 1 Masseur, 1 M.D., and 1 from Dept. of Health. For Opticians, board of 4 will draw up regulations, consisting of 1 optician, 1 optometrist, 1 oculist, 1 from Dept. of Health—No regulations to be drawn up until after prorogation of House.

Motion: "THAT the Registrar's report be accepted as the report of the Committee of Fifteen." Carried.

Reading of Communications, Petitions, Etc. to the Council

Communication Re Dr. ..... A confidential report on the condition of Dr. ....., under date of April 10, 1948, was presented to the Council.

The Council were of the opinion that more detailed information would be required before any action could be taken.

Motion: "THAT the Discipline Committee make a detailed investigation into the whereabouts of Dr. ..... and report to the October meeting of Council." Carried.

Communication From the College of Physicians and Surgeons of British Columbia, Re Remuneration to Members of Council, and Specialists

A communication was received from the Registrar of the College of Physicians and Surgeons of British Columbia, requesting confidentially the amount paid to members of the Manitoba Council. On receiving the Registrar's letter, he stated that the fee paid to members of the B.C. Council had recently been raised.

Motion: "THAT this matter be postponed until the October Council meeting." Carried.

A further communication was received from the Registrar of the College of Physicians and Surgeons of British Columbia, stating that the C.P. & S., of B.C. were considering the granting of specialist recognition in B.C., and were bringing the matter up before their annual meeting in May. He inquired whether the C.P. & S. of Manitoba had come to any definite decision as regards specialists. Replying to the Registrar's letter that the C.P. & S. of Manitoba had not reached any definite decision regarding specialists, the Registrar of B.C. stated that it would be sometime before definite conclusions would be arrived at in B.C. as to who would be registered as specialists and by what means. He stated further that it has been a bone of contention for many years, and men have been registered as specialists whom they felt had no right to such recognition.

The Registrar stated that in Ontario the Council of the College has set up a specialist register in which they recognize in a general way those who have specialist standing with the Royal College of Physicians and Surgeons. He said that the list has not been altogether confined to those who have Royal College qualifications.

Last fall Saskatchewan raised the same question, and the M.M.A. felt that it was not in the jurisdiction of the Association.

In Alberta specialists are designated by the University.

After considerable discussion the following motion was passed:

Motion: "THAT no action be taken." Carried.

Communication From the Manitoba Medical Service Re Repayment of Loan

A letter of thanks was presented from the Medical Director of the Manitoba Medical Service, enclosing the final balance of the loan receive from the College of Physicians and Surgeon Acknowledgment was made by the Registrar.

Communication From the Children's Hospital Building Fund

The Registrar presented a request from th Children's Hospital Building Fund through th Medical Arts Business Bureau Ltd., for a donatio to the Building Fund. The Council were of th opinion that as each doctor would be canvasse individually, it would not be necessary for th College to make a donation.

Motion: "THAT no action be taken." Carrie

Miscellaneous and New Business

Change of Name.

. . . . . .

Motion: "THAT the matter be filed."

Gordon Bell Memorial Fellowship

The Registrar presented the following repor received from Dr. Jan Hoogstraten the last re cipient of the Fellowship.

May 5th, 194

Dear Sir:

Last year I was the recipient of a Gordon Bel Research scholarship but in all this time, I hav never forwarded a report of my studies and pro gress since arriving in England. For this, I apologize, and now submit the following brie resume.

My first six months were spent in the Unit o Animal Physiology as a student, under the direc tion of Sir Joseph Barcroft. Here I assisted in ex periments in foetal physiology, perforaing Si Joseph's blood gas analyses.

During this period also, I constructed an oxyge dissociation curve for blood from a case of un treated pernicious anaemia, showing that in thi case, the affinity of the haemoglobin for oxyge had decreased from normal haemoglobin values.

During the experiments in foetal physiology I began a cytological study of the bone marrow and peripheral blood of sheep foetuses, lambs, an ewes. In the foetuses I have attempted to corre late the amount of erythropoiesis with the oxyge tension of the blood. I hope to have this work ready for publication within the next two months.

Shortly before his death in March, 1947, Si Joseph Barcroft arranged that I begin in vitro culture studies of leukaemia at the Strangeways Laboratory. I worked at that Institution until November, 1947, developing a modified Osgood tissue culture technique and have compared the growth of leukaemic cells in normal serum and leukaemic serum. Consequent to this work, I was elected an Elmore student in Medical Research in the department of Medicine and have enrolled as a Ph.D. Candidate in Downing College working under the supervision of Sir Lionel Whitby—

Regius Professor of Physic. The subject of my thesis will be the Nature of Leukaemia as deduced from a Pathological Study and in Vitro Culture Methods.

At present I am studying lymphatic leukaemia in dogs and the effects of treatment with urethane and di-isoprophyl-fluorophosphonate. Recently I have collaborated with Dr. Robin Coombes in a study of hemolytic disease of the newborn in horses. We have also attempted to produce the disease in rabbits by immunizing or sensitizing does to bucks erythrocytes and then mating them, and have had some measure of success in this venture.

The Gordon Bell Scholarship has given me opportunities in England for which I am duly grateful. Although my work has as yet been unproductive in the way of published works, the experience I am gaining is of inestimable value to me and I hope this year will see some published papers with due acknowledgement to the Gordon Bell Scholarship.

Yours sincerely,

Jan Hoogstraten.

The Registrar advised that the trustees of the Gordon Bell Memorial Fellowship were Dr. W. G. Campbell, Dr. Wm. Turnbull and Dr. J. S. McInnes with Dr. T. H. Williams, ex-officio, and that their term of office was continuous until resignation.

Payment of Janitor

Motion: "THAT the janitor be paid the sum of Five Dollars ($5.00) for his services." Carried.

The meeting adjourned.

June 4, 1948 — Registration Committee

Student Registration granted: Howard Alan Guest, resident of Stonewall, Manitoba, attending Queen's University. Presented his Grades XI and XII standing, and a certificate of his attendance at first year Medicine at Queen's University.

Dr. John Silny, graduate from Prague University. He attended final year at McGill University, and received his M.D. Degree in 1948. He is at present completing one year's interneship so that he will be eligible to write the examinations of the Medical Council of Canada.

Enabling Certificate granted: Dr. Hsueh-Yen Tso, B.S., Yenching University, Peiping, China, 1927; M.D. Peiping Union Medical College, Peiping, China, 1931.

Temporary Licence Granted: Dr. John Taylor MacDougall, B.A., University of Alberta, 1933; M.D., C.M., McGill University, 1937; L.M.C.C., 1937; F.R.C.S., Edinburgh, 1947; Certificate in General Surgery, R.C.P. & S. (C), 1947.

Registration granted: Dr. Henry John Furston, M.R.C.S., England, 1943; L.R.C.P., London, 1943.

Dr. Joseph Harton Rayner, M.R.C.S., England, 1936; L.R.C.P., London, 1936; D.P.H., Royal Institute of Public Health and Hygiene, 1947.

September 1st, 1948—Registration Committee

Registration Confirmed: Dr. Francis Patrick Doyle, B.Sc., University of Manitoba, 1943; M.D., University of Laval, 1948; L.M.C.C., 1948.

Dr. Hubert Delaquis, B.A., University of Manitoba, 1941; M.D., University of Montreal, 1947; L.M.C.C., 1947.

Dr. Hubert Hjalmar Atkinson, M.R.C.S., England, 1934; L.R.C.P., London, 1934; M.B., B.S., University of London, 1935; F.R.C.S., Edinburgh, 1944.

Dr. John Noel Roberts Scatliff, M.B., B.S., University of London, 1941.

Temporary Licence Confirmed: Ross Warrington Willoughby, M.D., University of Toronto, 1946; L.M.C.C., 1946.

Student Registration: Applications were received from Kingsley M. Morrison and Silvio Joseph Onesti, students at McGill University; and Mahabir Rampersad Maharajh, student at Ottawa University. The Registration Committee were of the opinion that student registration is required only of Manitoba students.

Enabling Certificates Granted: Dr. Andrew Paul Haynal, B.A., Emmanuel Missionary College, Berrien Springs, Michigan, 1943; M.D., College of Medical Evangelists, 1948.

Dr. Ian Walter de Grave Gregory, L.R.C.P., London, 1948; M.R.C.S., England, 1948; M.B., B.Ch., University of Cambridge, 1948.

Registration Approved: Dr. James Ernest Garson, L.M.S., University of Madras, India, 1925; L.M.S.S.A., London, 1935; M.R.C.S., England, 1936; L.R.C.P., London, 1936.

Dr. Thomas Arthur Horsley, M.D., College of Medical Evangelists, 1945; Diplomate, National Board of Medical Examiners, 1945; L.M.C.C., 1948.

Dr. Walter Maynard Shaw, M.D., C.M., Dalhousie University, 1948; L.M.C.C., 1948.

Dr. Velda Agnes Jenecke Weber, B.S., Pacific Union College, Angwin, Cal., 1940; M.D., College of Medical Evangelists, 1941; Diplomate, National Board of Medical Examiners, 1942; L.M.C.C., 1947.

Dr. William Seddon Lewis, M.R.C.S., England, 1941; L.R.C.P., London, 1941.

Dr. William Watt, M.B., Ch.B., University of Aberdeen, 1942; D.P.H., University of Aberdeen, 1948.

Dr. David William Burgess, M.R.C.S., England, 1941; L.R.C.P., London, 1941.

Registration Deferred: Dr. William LeGrande Cooper, (refer Reg. Comm. January 9, 1948, and Exec. Comm. February 17, 1948) Deferred by Registration Committee, pending receipt of Certificate of Credit under the Basic Science Act.

(To Be Continued)

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1948		1947		TOTALS	
	June 13 to July 10,'48	May 16 to June 12,'48	June 15 to July 12,'47	May 18 to June 14,'47	Dec. 28,'47 to July 10,'48	Dec. 29,'46 to July 12,'47
Anterior Poliomyelitis	2	0	10	0	5	10
Chickenpox	307	342	133	180	1795	773
Diphtheria	5	0	3	7	13	59
Diphtheria Carriers	0	1	1	2	1	15
Dysentery—Amoebic	0	0	0	0	0	0
Dysentery—Bacillary	3	0	0	2	3	3
Erysipelas	1	4	2	3	18	27
Encephalitis	1	0	0	0	1	1
Influenza	3	4	4	4	108	83
Measles	138	390	344	484	679	6354
Measles—German	0	2	0	4	31	32
Meningococcal Meningitis	2	0	0	0	9	9
Mumps	119	242	31	85	1264	1130
Ophthalmia Neonatorum	0	0	0	0	0	0
Pneumonia—Lobar	13	12	9	16	102	140
Puerperal Fever	0	0	0	0	1	3
Scarlet Fever	16	24	11	20	134	135
Septic Sore Throat	1	1	0	5	14	14
Smallpox	0	0	0	0	0	0
Tetanus	1	0	1	0	1	2
Trachoma	0	0	0	0	0	2
Tuberculosis	115	93	218	256	659	954
Typhoid Fever	0	2	3	0	4	4
Typhoid Paratyphoid	0	0	0	0	0	0
Typhoid Carriers	0	0	0	0	0	1
Undulant Fever	3	4	1	2	9	6
Whooping Cough	9	23	79	71	205	704
Gonorrhoea	127	119	151	178	824	898
Syphilis	33	38	55	53	279	330
Diarrhoea and Enteritis, under 1 yr.	17	21	19	25	106	107

Four-Week Period June 13 to July 19, 1948

DISEASES (White Cases Only)	*743,000 Manitoba	*906,000 Saskatchewan	*3,825,000 Ontario	*2,962,000 Minnesota
*Approximate population.				
Anterior Poliomyelitis	2	2	16	4
Chickenpox	307	158	1613	....
Diarrhoea and Enteritis	17	....	....	....
Diphtheria	5	....	4	3
Dysentery—Amoebic	....	....	....	2
Dysentery—Bacillary	3	1	....	....
Erysipelas	1	....	5	....
Infectious Jaundice	....	....	4	....
Influenza	3	....	28	....
Malaria	....	....	....	3
Measles	138	11	3125	307
Measles, German	....	4	34	....
Meningococcal Meningitis	2	....	4	5
Mumps	119	174	573	....
Pneumonia, Lobar	13	....	....	....
Scarlet Fever	16	1	216	52
Septic Sore Throat	1	....	2	....
Tetanus	1	1	....	....
Trachoma	....	2	....	....
Typhoid Fever	....	2	2	1
Typh. Para-Typhoid	....	1	....	....
Tuberculosis	115	56	135	368
Undulant Fever	3	....	4	13
Whooping Cough	9	23	35	16
Gonorrhoea	127	....	316	....
Syphilis	33	....	172	....

ANNOUNCEMENT

Tetanus Toxoid has now been added to the list of biologics supplied free of cost to the physicians in Manitoba by the Department of Health and Public Welfare. It may be obtained as the straight tetanus toxoid and also combined with (1) diphtheria toxoid, (2) diphtheria toxoid and pertussis vaccine, and (3) typhoid-paratyphoid vaccine. Directions are in each package.

Only a few cases of tetanus are reported in the province each year so the indication for tetanus toxoid is not great. Use your own judgment.

♦

DEATHS FROM REPORTABLE DISEASES

For Four-Week Period June 15 to July 13, 1948

Urban—Cancer, 37; Measles, 1; Pneumonia (other forms), 6; Syphilis, 1; Tuberculosis, 9; Diseases of the Pharynx and Tonsils, 1. Other deaths under 1 year, 14. Other deaths over 1 year, 167. Stillbirths, 11. Total, 192.

Rural — Cancer, 31; Influenza, 1; Measles, 1; Pneumonia (other forms), 9; Tuberculosis, 17; Diarrhoea and Enteritis (under 1 year), 7; Septicemia and Purulent Infection, 1; Dysentery, 2. Other deaths under 1 year, 15. Other deaths over 1 year, 177. Stillbirths, 13. Total, 205.

Indians—Influenza, 2; Pneumonia (other forms), 3; Tuberculosis, 3; Diarrhoea and Enteritis (under 1 year), 2. Other deaths under 1 year, 5. Other deaths over 1 year, 3. Stillbirths, 2. Total, 10.

BOOK REVIEWS

Clinical Neuro-Ophthalmology, by Frank B. Walsh, M.D., F.R.C.S. (Ed.). Associate Professor of Ophthalmology, The Johns Hopkins University. Williams & Wilkins Company, Baltimore. $18.00.

Only one word can describe this book and the word is "monumental." It extends to 1,532 large pages of small type, and of these over a hundred are devoted to a very full index. The text, which runs in two columns for easy reading, is amplified by about 400 illustrations and over 500 case histories. In its scope the work is encyclopedic. Beginning with anatomy which is fully illustrated and discussed it goes on to a consideration of all parts of the ocular apparatus. It shows that the eye is not only the "mirror of the soul" but that it is also a reflector of very many disorders of great variety. Thus it deals more fully than one would expect with such conditions as disorders of metabolism, of the circulatory system, of muscles, of the endocrine glands, etc. Everything that touches upon the eye is included. All the common conditions are fully covered and few of the rarities are omitted. In the chapter devoted to infections and parasitic invasions of the nervous system there are sections of diseases due to viruses, bacteria, molds, parasites, protozoa and spirochetes; syphilis being particularly fully dealt with. The complications of treatment are not overlooked. There are large comprehensive chapters on heredofamilial and degenerative diseases, and on congenital and developmental abnormalities and diseases of the eyes and central nervous system. Ninety pages are given to toxic and metabolic diseases. The discussion on tumors occupies 175 pages. The chapter on injuries by physical agents covers everything from head injury to wasp stings and spider bites. A chapter is given to epilepsy, migraine and similar disorders, and another to hysteria, malingering and traumatic neuroses. The final chapter, on drugs, poisons and toxic amblyopias, discusses the effects of a large list of drugs including streptomycine.

Altogether it is difficult to imagine a more valuable reference book for the ophthalmologist, the neurologist and the internist. But it will prove useful also to those in general practice who make a habit of thorough investigation.

This is a book that would invite purchase under any circumstances but when we recall that Frank Walsh is a Manitoba graduate, we read his pages with added pleasure. Not only do we marvel at the industry, knowledge and enthusiasm necessary for the book's production, but we feel a sense of personal pride in the fact that this magnum opus comes from the pen of a fellow alumnus.

Personality and Its Deviations. An Introduction to Abnormal and Medical Psychology. George H. Stevenson, M.D., F.R.S.C. Professor of Psychiatry, University of Western Ontario; Superintendent of the Ontario Hospital, London, Ontario; Past President, American Psychiatric Association. Leola E. Neal, M.A., Ph.D. Assistant Professor of Psychology, University of Western Ontario; Dean of Women, University of Western Ontario. Ryerson Press, Toronto, Ontario. Price, $4.00.

Said Alexander Pope "The proper study of mankind is man" and an understanding of human behaviour has become increasingly necessary for practitioners many of whom have had little or no academic instruction in psychobiology or psychopathology. For such readers the "heavy" volumes make dull and scarcely profitable reading. What they want is something sufficiently simple to give them an introduction to the more profound authors and sufficiently comprehensive to cover the whole field.

The authors of Personality and its Deviations had these facts in mind when they wrote their book. They had in mind the uninformed practitioner and also the "intelligent layman" to whom so many similar works are directed. It is therefore written with a simplicity calculated to attract the latter while it gives the medical reader the essence of the matter and, through its bibliography, informs him where he can get fuller instruction.

The book is divided into four parts. The first deals with normal personality, its construction, variations and deviations. It includes chapters on heredity, environment and body-mind relationships or "psychosomatics."

Having shown the make-up of personality the authors in the second part consider its motivation. In this part the two great forces emotion-instinct and intelligence are considered under the headings of Emotion and its Deviations; Instinct and its Deviations, Intelligence and Emotion-instinct and those matters arising therefrom—Self Preservation and Self Destruction, Race Preservation and Psycho-sexual Development, Personality management and Intelligence Testing.

Part Three deals with disorganized personalities and the evidence of disorganization such as delusions, hallucinations, deviations of consciousness and of memory and the like. The fourth part seeks to explore the prophylactic measures whereby mental health may be fostered and maintained.

Those whose knowledge of this most important branch of medicine is scanty will find Dr. Stevenson's book a great help. It will break trail for them and see to it that their feet are set in the right path. The bibliography appended to each

chapter indicates the most useful advanced reading. The book is clearly and interestingly written and contains a number of helpful diagrams, tables and illustrations. Those who attended the Convention meetings at which Dr. Stevenson spoke will need no inducement to read his book, while those to whom he is personally unknown may be certain that this work is well worth their consideration.

Contaminated Drugs

Federal Security Agency

Food and Drug Administration, Washington 25, D.C.

Druggists and the medical profession were urged today by the Federal Security Agency's Food and Drug Administration to return all stocks of Siliform Ampuls to the manufacturer, the Heilkraft Medical Co., Dorchester, Mass. This injection drug which should be sterile is potentially dangerous since samples collected on the market contain living organisms.

Siliform is injected by some physicians and osteopaths in the belief that it will relieve patients suffering with rheumatism, as claimed by the manufacturer.

The Food and Drug Administration found the contaminated samples after a routine inspection at the Heilkraft factory disclosed that the Siliform Ampuls had been manufactured without sterilization. Intensive recall efforts by the manufacturer and the Food and Drug Administration for the past 2 weeks have not brought in all the contaminated stocks. The article, which moves slowly, was shipped to 37 states from Maine to California and later was redistributed by wholesalers who cannot trace many of their sales. Some going back as far as 1946 have been found on the market. These ampuls may be in the hands of doctors, hospitals, clinics, and retail and wholesale druggists.

Annual Meeting of Society for Crippled Children and Adults

The 28th annual convention of the National Society for Crippled Children and Adults, Inc., will be held at the La Salle Hotel, Chicago, November 15-17.

Many outstanding speakers in the fields of medicine, health and education will be on hand to present facts on progress in work with the handicapped during the past year, according to Lawrence J. Linck, executive director.

The convention will be attended by physicians, therapists, educators, workers with the handicapped and representatives of National Society's more than 2,000 state and local units throughout the United States, Canada, Alaska and Hawaii.

THE TREATMENT OF PINWORM INFESTATION

"VERMILET"
Tablets

Enteric coated tablets of Gentian Violet "Frosst"

Infestation with pinworms is common in children and not unknown in adults. The high incidence of infestation revealed in recent surveys makes this condition a major public health problem. Symptoms may be entirely absent. Diagnosis is best established by using The National Institute of Health technique of stroking the skin-anal margin with a cellophane swab in the morning before bathing, and examining the swab for ova of the parasite.

The demonstration of pinworms in one member of a family should render the entire family suspect, and all infested individuals should be treated simultaneously.

Fortunately, 90% of cases can be cured within a short time with little inconvenience. Clinical records show that the most effective treatment is the administration of gentian violet, in the form of tablets, Vermilet "Frosst". These tablets are specially made to pass undissolved through the stomach and to dissolve in the lower part of the ileum.

DOSAGE

INFANTS:—Under three years of age 3/20 gr. (9.6 mg.) for each apparent year of age. For children unable to swallow a tablet, it is suggested that the tablet be concealed in a teaspoonful of oatmeal, and the child will swallow the tablet with a bolus of oatmeal.

CHILDREN:—Over 3 years of age, 3/20 gr. (9.6 mg.) for each apparent year of age, divided in three parts and taken before meals. From 10 to 16 years of age, one tablet of ½ gr. (32 mg.) three times daily before meals.

ADULTS:—Two tablets of ½ gr. (32 mg.) three times daily before meals.

Repeat dose daily for 8 days, rest for one week, then repeat dose for additional 8 days. No patient should be discharged as cured unless 3 or 4 swabs, examined at intervals of a week apart, show absence of ova.

"VERMILET"
Tablets

E.C.T. No. 409 "Frosst" 3/20 gr. (9.6 mg.)
E.C.T. No. 410 "Frosst" ½ gr. (32 mg.)

Bottles of 200 and 500 tablets.

NOTE:—Gentian violet is contra-indicated in heart disease, hepatic and renal disease, gastro-enteritis, pregnancy, and in the presence of febrile or debilitating diseases.

A package of swabs and literature describing technique for demonstrating the ova will be sent free upon request.

Charles E. Frosst & Co.
MONTREAL CANADA

Blue Shield or Compulsory Government Insurance*

The dangers that threaten the free practice of medicine in this country are fast becoming critical, and still we delay in uniting in decisive action to meet them.

We waste precious time in quarreling among ourselves over petty questions of local sovereignty. We amuse ourselves by setting up fantastic straw men, and dissipate our energies in knocking them down, while our enemies have been uniting against us in one national effort. We have thus far done no more than fight a series of rear-guard actions with small unorganized and unco-ordinated groups. I know of no more certain road to disastrous defeat.

Our national leaders seem to be purposefully blind to the social changes that are taking place. It is impossible to halt a movement by merely refusing to recognize its existence; and this movement toward extending the benefits of adequate medical care to all of our citizens has already gained too much momentum to be halted by any means. The last hope of American medicine lies in abandoning our present position in the rear of the column, where we have been holding back, and establishing ourselves firmly in the forefront, where we can guide and direct the movement into paths that are the best for our people as well as best for our profession. I emphasize that the welfare of our people must be given at least as much consideration as the welfare of the health professions. Too many physicians regard medical care as their exclusive prerogative. We must recognize that the consumer of medical care also has a great stake in it; and, if there has existed any doubt as to this, it should have been dispelled by the deliberations of the National Health Assembly, held in Washington, early in May.

I shall offer no defense of the motives that prompted the organization of this Assembly. They may have been, as has been charged, largely political. But however impure the motives, only a very stupid person could have listened to the discussions in the Section on Medical Care and come away unimpressed both by the strength and the determination of the groups committed to an effective program for prepayment of medical care. I emphasize "effective," because the preponderant opinion there expressed was that existing plans are acceptable only so far as they go, that they do not go far enough, and that, if they are to be fully acceptable as a substitute for compulsory Government health insurance, the coverage they offer must be extended considerably, and must be uniform throughout the country. In fact, a resolution to the effect that only a compulsory Government insurance plan could satisfy these criteria was proposed, and vigorously supported by the American Federation of Labor, the Congress of Industrial Organizations, the Co-operative League of America, the National Co-operative Health Federation, the National Federation of Settlement Workers, the Committee for the Nation's Health, the American Association of Social Workers. the Physicians' Forum, the National Consumers' League, the National Women's Trade League, the United Mine Workers, the American Veterans' Committee, the National Farmer's Union, the Physicians' Committee for Improvement of Medical Care, the League for Industrial Democracy, and the Association for the Advancement of Colored People. This conclusion was not adopted, for the reason that adoption of any conclusion required the unanimous approval of the Steering Committee; and a single dissent was sufficient to defeat a proposal. But the array of strength behind this conclusion should convince even the die-hard tories in the health professions that the threat of nationalization of medical care in this country is real, is acute, and soon will be, if it is not already, sufficiently great to precipitate action by the Congress. The press carried, yesterday, the news that the Wagner-Murray-Dingell Bill would not be reported out of Committee during this session of the Congress; but it also stated that hearings upon this Bill would be resumed in March, 1949. So the Bill is far from dead. The representatives of the people, in Congress assembled, are swayed by numbers of voters rather than by principles. Even discounting the smaller and the more radical groups demanding national health insurance, we still have the A.F. of L., the C.I.O., the National Women's Trade League, the United Mine Workers, and the Association for the Advancement of Colored People demanding national health insurance. These represent a lot of votes. I am sure they represent more votes than have yet been mustered in favor of equal rights for Negroes, and look what has been accomplished in this direction within a very short time! If this array of political strength is not enough to shock the medical profession out of its lethargy, then we are hopelessly lost and there is no use continuing the struggle.

What, then, will be the future of the voluntary prepayment plans for medical care—both commercial and non-profit? Those demanding national health insurance were generous enough to state that the voluntary plans should continue in operation after the inauguration of national health insurance. This, of course, was but a courteous gesture since it would be impossible for voluntary plans to compete with a government plan. The

*A speech delivered at the Conference of Presidents and Other Officers of State Medical Associations, 20 June, 1948, by Paul R. Hawley, M.D., Chief Executive Officer, Blue Cross-Blue Shield Commissions.

THEELIN:

continuing leadership in estrogen therapy

naturally occurring

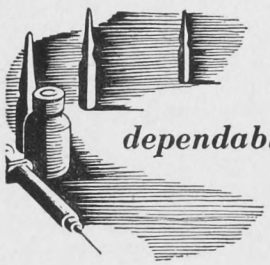
THEELIN is a *naturally occurring* estrogen It is well tolerated and can be administered without significant side reactions or untoward effects.

THEELIN is a *pure crystalline* estrogen. Since it is not a mixture and does not contain extraneous substances, its physiologic effectiveness is accurately determined by weight.

pure crystalline

THEELIN is a *highly potent* estrogen. One ten-thousandth (0.0001) of a milligram is equivalent to one international unit. Because of THEELIN's potency, symptoms of the menopause and other estrogen-deficiency states may be readily and effectively relieved.

THEELIN is a *dependable* estrogen. It has stood the test of time. The first estrogenic hormone to be isolated in pure crystalline form and the first to assume clinical importance, THEELIN may be depended on for its reliable and predictable estrogenic effects.



dependable

THEELIN is available as **THEELIN AQUEOUS SUSPENSION** in ampoules of 1 mg. (10,000 I.U.) and 2 mg. (20,000 I.U.)

THEELIN IN OIL in ampoules of 0.1 mg. (1000 I.U.) 0.2 mg. (2000 I.U.), 0.5 mg. (5000 I.U.) and 1 mg. (10,000 I.U.);

STERI-VIAL® THEELIN IN OIL in vials of 10 cc., each cc. containing 1 mg. (10,000 I.U.); and THEELIN Vaginal Suppositories, containing 0.2 mg. (2000 I.U.).

PARKE, DAVIS & CO., LTD. • WALKERVILLE, ONTARIO

MEDICAMENTA VERA · PD & CO.

handicap would not be one of cost, because the voluntary plans can do the job cheaper than the Government can. But the fact that the government plan would be supported at least one-third by tax money, and that everyone would have to pay this tax, whether or not he subscribed to a voluntary plan, would dissuade the taxpayer from supporting two plans at the same time.

Since it is impossible for voluntary plans to survive if and when national compulsory health insurance comes, we are going to have one or the other type of prepayment health insurance—not both. So, the future of the voluntary plans depends entirely upon the prevention of the enactment of national compulsory health insurance legislation.

This cannot be prevented through political manipulation. It is my considered opinion that, if left to popular vote, this legislation might pass today. Certainly the strength mustered in its support at the National Health Assembly surprised even its protagonists—and was something of a shock to me.

But this disastrous legislation can be prevented if the voluntary plans meet every reasonable demand for health insurance. I specify "reasonable demand" because, as all of us know who are familiar with the problems involved, some of the demands expressed at the National Health Assembly are impossible of fulfillment at the present time, and for some years to come.

There were unanimously adopted by the Medical Care Section seven criteria for measuring the effectiveness of prepayment plans in meeting the medical care needs of the people. I shall discuss only the more important of these as they point the goals which must be reached by voluntary prepayment plans if they are to be considered adequate to the peoples' needs.

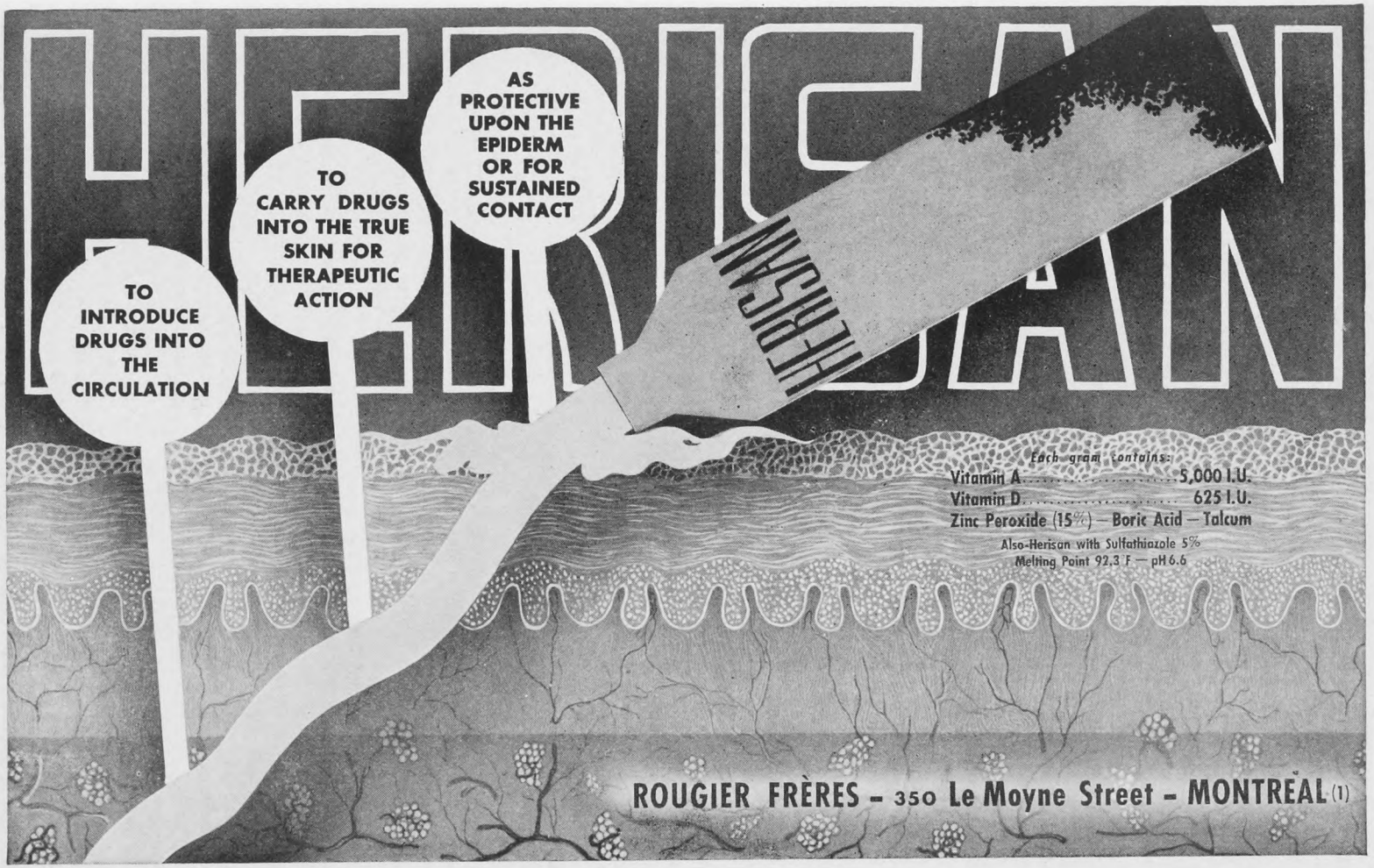
The first criterion is "The extent to which a prepayment plan makes available to those it serves the whole range of scientific medicine for prevention of disease and for treatment of all types of illness or injury." To meet this criterion, voluntary plans must be in a position to offer as comprehensive a coverage as the public demands, regardless of cost. Since many people neither desire so complete a coverage, and are unwilling or unable to pay its cost, this means that plans will have to offer more than one type of contract. This will not be at all difficult once a competent actuarial service is established. I can think of no good reason for limiting the offering of a prepaid medical care plan to a single type of contract. We must always, of course, offer a contract that is within the economic reach of the low-income groups who must bear all or part of its costs. But these large union groups are demanding a much more comprehensive service, and are willing and able to pay for it. We simply must be in a position to offer them a contract that meets their requirements, or we shall not only be forced out of business but also we shall have compulsory Government health insurance as a reality instead of as a threat.

The fact that the fee schedules for the low-income group contracts are inadequate for the higher-income contracts need give no physician any concern. It is quite easy to arrange a separate fee schedule for each type of contract. For the higher-income groups, the fees should be higher, and should correspond to the fees normally charged such groups. The wealthier groups expect that—in fact, I am sure that they would demand it, because they do not want to be regarded as charity patients—and they are willing to pay the additional premium for their coverage.

What can it matter to the participating physician whether the patient pays the bill from his private income, or whether the bill is paid by the medical care plans, so long as the amount paid corresponds with the fee customarily charged in that income level? Even if there is some objection to such a procedure, the alternative is to lose millions of potential patients to employee-benefit associations and medical co-operatives operating their own clinics and hospitals. I cannot stress too strongly the fact that this movement has already reached the point where the medical profession has the choice only of making a reasonable effort to meet the requirements of these large groups of consumers of medical care, or of watching the private practice of medicine in this country being rapidly strangled by either co-operative or Government medicine. No other alternatives are left. All other alternatives have been lost in the ten or fifteen wasted years in which organized medicine has pursued an entirely negative course in dealing with this social problem.

The next point of the greatest importance is that these large groups will not be satisfied with anything short of uniform coverage for their members regardless of their place of residence. They simply will not deal with 51 separate Blue Shield plans. Already the United Mine Workers, with 400,000 members, have a 10-cent per ton levy solely for health and welfare. As we assemble here, a union with more than 1,000,000 members is negotiating with a large industrial corporation for a 10-cent per hour increase in wages, to be devoted exclusively to a health and welfare program. Another union, with more than 1,000,000 members, has already appointed a medical advisory council to formulate a prepaid health program for its members, to be paid for by a similar 10-cent per hour raise in pay.

Is organized medicine guiding and directing these programs? It is NOT! I happen to know


HERISAN
AS PROTECTIVE UPON THE EPIDERM OR FOR SUSTAINED CONTACT
TO CARRY DRUGS INTO THE TRUE SKIN FOR THERAPEUTIC ACTION
TO INTRODUCE DRUGS INTO THE CIRCULATION
HERISAN
Each gram contains:
Vitamin A ..... 5,000 I.U.
Vitamin D ..... 625 I.U.
Zinc Peroxide (15%) — Boric Acid — Talcum
Also-Herisan with Sulfathiazole 5%
Melting Point 92.3°F — pH 6.6
ROUGIER FRÈRES - 350 Le Moyne Street - MONTREAL (1)

some of the members of this medical advisory council of this gigantic union. I can tell you that they are openly committed to Government compulsory health insurance. Let me give you the names of some of them—Fred Mott, who is directing the Government medicine program in Saskatchewan; Dean Clark, who is director of H.I.P. in New York; Jack Peters, who is Secretary of the Committee of Physicians for the Improvement of Medical Care. I can tell you further that the plan for the medical care of this large union, which was proposed at the first meeting of this medical advisory council, was similar to that of the Health Insurance Plan of New York—the establishment of clinics in every centre of this union population, and these clinics to be operated by salaried physicians. This Association is on record as opposing such a plan for medical care.

Why was not organized medicine approached for advice and counsel in the establishment of these huge programs for prepayment of medical care? I'll let you answer that question. But doesn't it shock you, doesn't it give you a feeling of insecurity that the leadership of these great movements, which will exert the most profound effect upon medical practice in this country—that the leadership in these movements has slipped from the grasp of organized medicine? I can tell you that it disturbs me deeply, and that I am convinced that the cause is lost unless you take prompt and effective action to regain control of medical practice in this country. I say "regain" because I am afraid you have already lost it, whether you realize it or not. And you are not going to regain it through the methods you have followed during the past ten years.

Some three weeks ago I had a conference with one of the most powerful, if not the most powerful, labor leaders in the United States. This organization, of which he is the President, controls many labor unions with millions and millions of members. He has already started this movement for a prepaid medical care program in two of his largest unions, and he assured me that it would be carried on throughout the labor empire that he controls. I am violating no confidence when I tell you that he exhibited a strong bias against the attitude that organized medicine has displayed up to the present moment. His closest welfare advisers made it very clear to me that they would deal with the voluntary non-profit prepayment medical care plans only if these plans met their requirements to a reasonable degree. They did not display an adamant insistence upon 100 per cent performance at once but they set forth a few principles upon which they would not compromise.

The two most important principles upon which they would insist in full were uniform coverage in every area in which their members reside, and a single contract with one labor-management board regardless of the number of individual medical care plans which would be involved in providing the service. There would be no negotiation with reference to these two principles—we would have to accept them or reject them as they stand.

These gentlemen also made it clear that they were opposed to indemnity insurance and would accept this type of contract only as a temporary expedient. They are committed to the principle of the service contract.

These requirements can be met, and met easily. But they cannot be met so long as our vision is limited by the boundaries of the small areas in which we live and practice medicine. The problem is one of national scope, and it cannot be solved by State and County Medical Societies acting independently. I can assure you that you will not even be listened to much less dealt with, upon any such basis.

Neither one of these requirements can be met, however, without the necessary machinery at the national level of Blue Shield Plans. You know full well that it would be impossible for 51 separate Blue Shield Plans to get together around a table and agree upon a uniform contract. Even if this were possible in one case, you must remember that different groups may demand different degrees of coverage, and this painful process would have to be repeated each time we were approached by a national group. The time required to effect such agreements would defeat us. These prospective clients demand an answer within days—not months.

For these reasons, only a National Service Agency, controlled by all the participating Blue Shield Plans, can possibly meet this urgent need. My own concept of such an agency is this:

1. It would be controlled by a board of directors elected by the participating Blue Shield Plans.

2. It would underwrite medical care programs of national scope; and, in turn would pass on to each local plan concerned the share of the business that lay within the area of that plan.

3. If any local plan desired to accept the entire risk of additional coverage offered in any contract, it would be free to do so. If, on the other hand, any local plan declined to carry the additional coverage demanded, the National Service Agency would carry the added risk, and pay the local plan for all such service rendered.

4. The National Service Agency would work only through local plans. It would write no contracts in any area covered by a plan that did not involve two or more plans, and it would offer no contract of itself except in areas not covered by any Blue Shield Plan.

5. The National Service Agency would have no control over any local plan other than to see that

agreements entered into with subscribers were carried out.

6. The existing organization of Associated Medical Care Plans would not be disturbed. The National Service Agency would be an underwriting organization, and not one of control.

As a physician, who is intensely interested in the future of medicine in this country, I cannot see the slightest danger in such a project. Each local Blue Shield Plan would preserve its present degree of autonomy, and the national agency would be one that served all the plans rather than one that controlled all the plans. And, don't forget one thing—it is either some such arrangement or be forced out of business. If we are not going to be in a position to serve these new millions of organized consumers of medical care, we had better announce that fact right now and liquidate our Blue Shield Plans. Sudden death is much preferable to a lingering, painful death; and slow death for us is certain—and maybe not so slow at that—unless we get in step with the rest of the country.

I mentioned earlier that straw men were being set up so that they could be knocked down. Perhaps the largest of these straw men is that this is just a scheme for Blue Cross to gain control of medical practice in this country. This is not only the largest of the straw men, it is also the most fragile. I work just as closely with the Blue Cross Commission as I do with the Blue Shield Commission. I have not seen the slightest evidence of any desire—much less, intent—on the part of the Blue Cross Commission to exert even the slightest control of the practice of medicine. The cry of "No Merger" has been raised against the two Commissions. I have been instructed by the Joint Executive Committee of the two Commissions to state that merger of Blue Cross and Blue Shield has never been considered. All that has ever been seriously proposed is a federation of the two groups for the single purpose of promoting the success of both. The leaders in Blue Cross believe, just as do the majority of leaders in Blue Shield, that we must effect enough co-operation between these two great organizations for us to offer prepaid medical and hospital care in one package. The public cannot understand why they should be forced to join two different organizations to protect themselves against the cost of illness—and, when you think of it, it is hard to explain. But joining hands solely for the purpose of offering prepaid health protection in one unit is a far cry from merging the two organizations under single control.

I beg of you not to be misled by any such vicious propaganda. So long as I remain in this position I shall defend medical practice just as zealously as I uphold the principles of Blue Cross. If there were any real areas of conflict between these two organizations, I would certainly discover them at once; and I can find none.

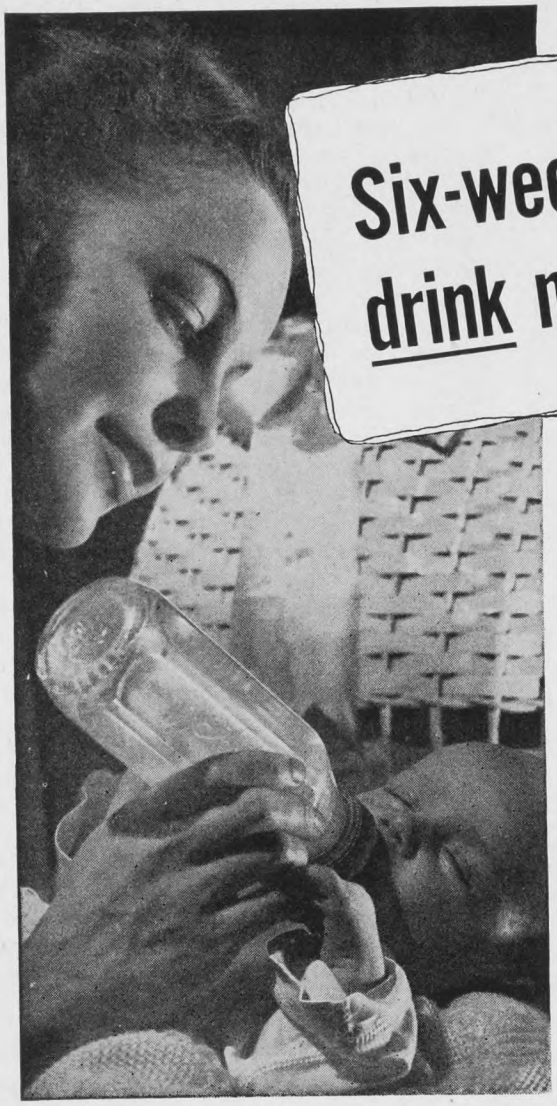
You did me the great honor last year of inviting me to address you at Atlantic City. I spoke to you very frankly at that time, pointing out the dangers to American medicine from within. That the majority of you approved my remarks, and believed in my complete devotion to our medical profession, is indicated by the fact that you have again invited me. I doubly appreciate this present honor; and I am again forcibly reminded of my great responsibility to the medical profession. I shall not, in the slightest, shirk this responsibility nor shall I ever compromise with my obligation to American medicine.

But my heart grows heavy as I see the indifference of many physicians to the threat to freedom in medicine that is becoming more menacing each day; and as I encounter the petty, selfish greed of a few physicians who had rather see the entire structure of American medicine wrecked than to concede one small personal advantage in the general interest.

If we get socialized medicine in this country, it will be organized medicine, and only organized medicine, that has brought this curse upon us. We, as physicians, will have only ourselves to blame. If I were among the group that wants socialized medicine in this country — if I were Channing Frothingham, or Ernst Boaz, or Jack Peters, or Michael Davis, or Isidor Falk—I would not exhaust much energy in making a great personal effort—I would relax and let organized medicine do the job for me. All that is necessary to bring socialized medicine to this country within a very short time is for organized medicine to pursue the same course that it has pursued for the past ten years.

The demand for more comprehensive medical care, and for an effective means of budgeting its costs, has grown, within ten years, from a whisper to a roar. Our people will not be denied much longer. If the medical profession does not at once assume the leadership, if it does not at once cease its double talk and double dealing with the voluntary non-profit prepayment plans, and throws its influence squarely and honestly behind these plans, we are going to have compulsory government health insurance in this country within three years.

I give free medicine a lease on life of three years solely because other heavy financial commitments of the Government will preclude the assumption of the additional burden of compulsory health insurance. The Marshall Plan and the rearmament program will keep the Government, and the taxpayers, strapped for the next few years. But, within three to five years—and I think it will be nearer three—either these measures to restore peace will have been successful, or we shall again



Six-weeks-old infants drink meat and thrive

Tests with Swift's Strained Meats result in better satisfied babies with higher hemoglobin level, higher red cell count.

In clinical feedings the protein intake of six-weeks-old infants was increased 25% by the addition of approximately one ounce of Swift's Strained beef, lamb, pork or veal to the formula. Results showed that meat-fed infants slept better, cried less than babies in the control group. The study indicates that Swift's Strained Meats added to the formula not only check the drop in hemoglobin, characteristic of this age, but actually promote hemoglobin and cell formation.*

Swift's Strained Meats make earlier meat-feeding easy

The individual particles of Swift's Strained Meats are so minute they will pass through the nipple of a nursing bottle. Even before solid foods are started, Strained Meats may be added to the formula to help provide the plentiful amounts of complete, high-quality proteins needed to support infants' rapid growth. Meat is also an abundant source of thiamine, niacin, riboflavin and minerals, notably iron.

Swift's Strained Meats, in six varieties, provide textures and flavors different from baby's other foods—help him form nutritionally sound eating habits. When you recommend Swift's Strained Meats, you know the meat is properly prepared. They're 100% meat, strained soft and smooth, cooked to retain a maximum of the nutrients, and trimmed to reduce fat content to a minimum.

Also Swift's Diced Meats for young children

Small, bite-size pieces of tender meat, firm enough to encourage chewing, easy to digest. Tempting meat flavors that help overcome anorexia in the older baby and young child.

For additional information, write Swift Canadian Co. Limited, Dept. B.M., Toronto 9, Ontario.

6 Strained • 6 Diced Meats

BEEF LAMB PORK
VEAL LIVER HEART

Ready to heat and serve

*MEAT IN THE DIET OF YOUNG INFANTS
Ruth M. Leverton, Ph.D. and George Clark, M.D.
Journal of the American Medical Association
(J.A.M.A. 134:1215, August 9, 1947)

All nutritional statements made in this advertisement are accepted by the Council on Foods and Nutrition of the American Medical Association.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

SWIFT QUALITY FOODS

SWIFT CANADIAN CO. LIMITED

e in a war. I believe we shall have peace; and st as soon as the taxpayer is relieved from this rrific burden of his investment in peace, you ay be sure the politicians will be ready to im- se upon him the burden of a compulsory health surance program—that is, unless by that time e have demonstrated that voluntary health in- rance is a completely satisfactory answer to the roblem. And I would emphasize further that, we start right now, it will take at least two ears to effect an organization that can do this b. We cannot afford to waste any more time in uitless discussions that lead us nowhere. We ust decide right now whether we are going to nite in this effort; and, if we are, we must cease ll delaying and obstructive tactics.

Don't be lulled into a sense of security by such ble studies on socialized medicine as have been ade by the Brookings Institution, and the Na- onal Industrial Conference Board, and other cap- ble agencies such as these. Of course, every inking person is convinced that socialized medi- ne would be a great mistake—a costly mistake oth in money and in health. But this issue will ot be decided by wisdom. It will be decided en- rely by emotion. Like President Coolidge's reacher, who was "agin sin," everyone is against ickness and death. Only a small minority of our eople can understand the dangers of socialized edicine—all they know is that they want every- ne to have good medical care, and they are not apable of choosing between the various ways in hich medical care can be better distributed. Only "fait accompli" will convince them—and so we ave only a short time in which to show them an ccomplished fact.

It is useless for the medical profession to ndertake the education of our people to the angers of socialized medicine. Our public rela- ions have been so miserable in the past few years hat a majority of our people suspect us of having nly a selfish, personal interest in this question. honestly believe that the medical profession does ore harm than good when it attempts to decry ocialized medicine—our motives are too suspect.

Don't be misled with such absurdities as the ssurance that the Government cannot make you ractice medicine if you do not want to. You see hat has happened in England. The members of he British Medical Association voted at first to ave nothing to do with government medicine. he majority was heavy—80 per cent pledging hemselves to remain outside the Government lan. But, as the deadline for participation ap- roached, British physicians by a small majority, oted to accept the government plan.

How long can you hold out in a strike against he Government? How many of you could stick it year with no income? And how many of you would stick it if you saw a minority group collecting all the gravy? You are trained in medicine. How many of you would be willing to forsake medicine and embark upon another career?

Don't let anyone fool you! If Government medicine comes, 90 per cent of you will be forced by circumstances to accept it, no matter how bitter a pill it will be for you to swallow. So, the only way to prevent this tragedy is to stop it before it arrives—there is little you can do about it after it comes. The medical profession can prevent this tragedy, but only by positive action that will meet the reasonable demands of these large groups. Consistently negative action has brought us to this critical juncture, and has played directly into the hands of the enemies of free medicine. Time is running against us. We can not longer delay.

This convention, which is about to open, promises to be the most important in the hundred years of existence of the American Medical Association. The great work of the past hundred years can be undone over night by unwise action during this week. I beg of you to weigh carefully the issues that will be presented. I ask you to weigh them in the light of the events of the past few weeks. I am as certain as I am that I stand here that, if this convention fails to encourage and support the expansion of the Blue Shield movement, the death knell of free medicine in this country will have been sounded.

General Practice Opportunity

The Rural Municipality of Brenda is anxious to secure a doctor to locate at Waskada. This is an old established practice. Municipal Plan of Payment for Services as per By-law schedule. Municipal house suitable for dwelling and office available at Waskada. Opportunity for private practice in large area in other municipalities. Extensive practice assured. For copy of By-law and full details, apply to W. T. Hartry, Secretary-Treasurer, Waskada, Man.